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IN THE

Supreme Court of the United States

SPENCER WADDELL,

Petitioner,

—v.—

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Did the Court of Appeals err by holding, in conflict with other Circuits, that the "direct threat" defense to a discrimination claim under the Americans With Disabilities Act – which applies when a plaintiff with a disability poses a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation," 42 U.S.C. § 1211(3) – is established as a matter of law when there is even an immeasurably low and purely theoretical risk of an event occurring that could cause death?

2. Did the Court of Appeals err by holding, in conflict with other Circuits, that the plaintiff has the burden of disproving the "direct threat" defense as part of the plaintiff's *prima facie* case of discrimination under the American With Disabilities Act?

PARTIES TO THE PROCEEDING

The parties to this proceeding are Spencer Waddell, Petitioner, and Valley Forge Dental Associates, Inc., Respondent.

Valley Forge Dental Associates was acquired by Monarch Dental Associates and is its successor-in-interest.

TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

OPINIONS BELOW 1

JURISDICTION 1

STATUTORY PROVISIONS INVOLVED 1

STATEMENT OF THE CASE 3

A. Spencer Waddell's Termination 3

B. The Expert Evidence 5

C. The Decisions Below 10

REASONS FOR GRANTING THE WRIT OF CERTIORARI 11

I. This Court Should Grant Certiorari Because the Eleventh Circuit's Holding That As A Matter of Law An Almost Zero, Purely Theoretical Risk of Harm Resulting in Eventual Death Constitutes a Direct Threat Is in Conflict With Controlling Decisions of This Court 12

II. This Court Should Grant Certiorari Because the Eleventh Circuit's Opinion Increases the Confusion Among the Courts of Appeals As To Whether A Purely Theoretical Risk of Serious Harm, Including Death, Is Sufficient to Constitute A Direct Threat As A Matter of Law 18

III. Certiorari Also Is Necessary to Resolve The Conflict Among the Courts of Appeals As To Which Party Bears the Burden of Proof On A Direct Threat Defense. 22

CONCLUSION 24

APPENDIX A1

Court of Appeals Decision A1

District Court Order and Decision A15

TABLE OF AUTHORITIES

CASES

Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997), *aff'd in part, vacated and remanded in part*, 524 U.S. 624 (1998) 20

Bragdon v. Abbott, 163 F.3d 87 (1st Cir. 1998), *cert. denied*, 526 U.S. 1131 (1999) 20, 21

Bragdon v. Abbott, 524 U.S. 624 (1998) ..... *passim*

Chalk v. United States Dist. Court, 840 F.2d 701 (9th Cir. 1988) 21

Dadian v. Vill. of Wilmette, 269 F.3d 831 (7th Cir. 2001) . 23

EEOC v. AIC Sec. Investigations, Ltd., 55 F.3d 1276 (7th Cir. 1995) 23

EEOC v. Amego, Inc., 110 F.3d 135 (7th Cir. 1997) 22

Hamlin v. Charter Township of Flint, 165 F.3d 426 (6th Cir. 1999) 21

Hartog v. Wasatch Acad., 129 F.3d 1076 (10th Cir. 1997) 23

Hutton v. Elf Atochem N. America, Inc., 273 F.3d 884 (9th Cir. 2001) 23

Montalvo v. Radcliffe, 167 F.3d 873 (4th Cir. 1999), *cert denied*, 528 U.S. 813 (1999) 19

Rizzo v. Children's World Learning Ctrs.,
84 F.3d 758 (5th Cir. 1996) 20, 23

School Bd. of Nassau County v. Arline,
480 U.S. 273 (1987) ..... *passim*

Stafne v. Unicare Homes, 266 F.3d 771 (8th Cir. 2001) ... 23

Waddell v. Valley Forge Dental Associates, Inc.,
276 F.3d 1275 (11th Cir. 2001) 1, 17

STATUTES

28 U.S.C. § 1254 (1) 1

42 U.S.C. § 12111 (3) 1

42 U.S.C. § 12111 (8) 1

42 U.S.C. § 12112 (b) 2

42 U.S.C. § 12113 2

42 U.S.C. § 12113 (b) 12

42 U.S.C. § 12182 (b)(3) 12

OTHER AUTHORITIES

Centers for Disease Control and Prevention,
HIV/AIDS Prevention Update (Nov. 30, 1998),
http://dvd.gov.nchstp/hiv_aids/pubs/faq/
faq30.htm 19

Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, MORBIDITY & MORTALITY WEEKLY REPORT 1991:
40 (RR. 8): 1-9 7

The Petitioner, Spencer Waddell, respectfully seeks a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The unreported decision of the federal district court is *Waddell v. Valley Forge Dental Associates, Inc.*, 99-00262-CV-CAP-1 and is reprinted in the appendix. (App. A15). The opinion of the Eleventh Circuit Court of Appeals is *Waddell v. Valley Forge Dental Associates, Inc.*, 276 F.3d 1275 (11th Cir. 2001) and is reprinted in the Appendix. (App. A1).

JURISDICTION

The Eleventh Circuit Court of Appeals entered its judgment on December 21, 2001. Jurisdiction is conferred upon this Court by 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 12111 (3) provides:

> The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.

42 U.S.C. § 12111 (8) provides in relevant part:

> The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that

such individual holds or desires.

42 U.S.C. § 12112 (b) provides in relevant part:

[T]he term "discriminate" includes –
(1) limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee; ...
(3) utilizing standards, criteria, or methods of administration –

> (A) that have the effect of discrimination on the basis of disability;...

(6) using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity;...

42 U.S.C. § 12113 provides in relevant part:

Defenses
(a) In general
It may be a defense to a charge of discrimination under this Act that an alleged application of qualification standards, tests, or selection criteria that screen out or tend to screen out or otherwise deny a job or benefit to an individual with a disability has been shown to be job-related and consistent with

business necessity, and such performance cannot be accomplished by reasonable accommodation, as required under this title.
(b) Qualification standards
The term "qualification standards" may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.

STATEMENT OF THE CASE

The petition for *certiorari* seeks this Court's review of two issues of law that are central to the interpretation of the Americans With Disabilities Act: *first*, whether a near-zero, purely theoretical risk causing eventual death is sufficient as a matter of law to establish that an individual with a disability poses a "direct threat" to others; and *second*, whether a defendant in an ADA case bears the burden of proof for establishing that a plaintiff's disability poses a direct threat. The facts relevant to the resolution of these questions are set out below; the appeal sought, however, turns on issues of law and not issues of fact.

A. Spencer Waddell's Termination

Dr. Eugene Witkin employed Spencer Waddell over several different periods from 1993 until 1997; between early 1996 and October, 1997, Mr. Waddell worked under the auspices of Valley Forge Dental Associates, Inc, which acquired Dr. Witkin's practice and retained him as a manager.[1] According to Dr. Witkin, Mr. Waddell

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[1]After Mr. Waddell was terminated, Valley Forge Dental Associates was acquired by Monarch Dental Associates, which exists today and is Valley Forge's successor-in-interest (R. 16 (Witkin Dep.), 5). For convenience the defendant-appellee is referred to as "Valley Forge"

performed his job well. (R. 16 (Witkin Dep.), 8-9).

Mr. Waddell is licensed by the State of Georgia as a dental hygienist and performs routine prophylaxis on patients' teeth. (R. 19, Exh. 1 (Waddell Aff.), ¶¶3, 8). As distinguished from the type of care dentists provide, "routine prophylaxis" involves the removal of deposits and accretions below the gumline. (R. 19, Exh. 2 (Marianos Aff.), ¶¶13, 15). Dental hygienists licensed in Georgia do not administer injections. (*Id.*, ¶¶6,7).

In September 1997, Dr. Witkin learned that Mr. Waddell is HIV positive (R. 16 (Witkin Dep.), 24-25). Mr. Waddell was removed from patient care and offered a clerical position at half the pay he had been earning, then was fired when he refused to accept this position. (R. 16 (Whelchel Dep.), 33-36; R. 34 (Waddell Dep.), 128; R. 4 (Answer), ¶3). Dr. Witkin removed Mr. Waddell from his position as a dental hygienist solely because he is HIV positive. (R. 16 (Witkin Dep.), 27, 39). He feared that there was a risk of HIV-transmission to patients and that he would lose patients if they found out that Mr. Waddell has HIV. (R. 16, 24). Dr. Witkin confirmed that he "could not get beyond" his understanding that the risk of HIV transmission could not be eliminated to zero, and that it was "irrelevant" to him whether the actual risk was great or small. (R. 16 (Witkin Dep.), 31-32). [2]

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throughout this brief.

[2] Dr. Witkin has no training concerning HIV transmission, and has never attended any seminars devoted to discussion of HIV and its impact on dentistry or taken any classes on infection control. (R. 16 (Witkin Dep.), 16). He thinks it is possible that HIV is transmitted through sweat. (*Id.*, 22). Dr. Witkin claimed that he reviewed "some" journal articles, but was unable to describe them, (*Id.*) and that somebody at Valley Forge contacted the Centers for Disease Control and Prevention [hereinafter, "CDC"] and was told that there was "a risk" (*Id.* at 20, 29, 31-32.). Dr. Witkin also claimed that he relied on the CDC's 1991 guidelines on

B. The Expert Evidence

The objective, expert medical evidence in this case consisted of testimony that unanimously concluded that Mr. Waddell does not present any real danger of HIV transmission to his patients. Dr. Marianos[3,4] testified, for example, that:

> [D]ental hygienists' fingers and sharp instruments are rarely simultaneously in the oral cavity ... Simply stated, one reason that hygienists' tools may look so intimidating is that they are designed to reach places where the hand cannot go. Routine prophylaxis,

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health care workers with HIV and hepatitis B.

[3] Dr. Donald Marianos holds a Master of Public Health degree and a Doctor of Dental Surgery degree. He currently teaches dental hygiene at Northern Arizona University. (Marianos ¶1). From 1989 to 1997, Dr. Marianos was a Captain in the United States Public Health Service at the CDC in Atlanta, where he was Director of the Division of Oral Health. While serving at the CDC, Dr. Marianos provided technical assistance to international, federal, state and local health organizations in the area of infection control and infectious diseases in dentistry. (*Id.*, ¶2). Dr. Marianos participated in the development of CDC's 1991 protocol concerning the management of HIV positive health care workers. (R. 18, Exh. J), and has worked with the Scientific Committee of the American Dental Association to develop its policies on infection control and HIV. (*Id.*, ¶3).

[4] The affidavits filed by Mr. Waddell's experts, Drs. Joseph Wilber, John Molinari, and Donald Marianos are cited in short form, i.e., with their surname and a paragraph number. The full citations are (R. 19, Exh. 3 (Wilber Aff.)); (R. 19, Exh. 4 (Molinari Aff.)); and (R. 27, Exh. 2 (Marianos Aff.)). The full citation for a supplemental affidavit by Dr. Marianos is (R. 27, Exh. 1 (Marianos. Aff.)); it is referred to herein as "Marianos Supp. Aff."

> including scaling and root planing, may conjure up images of copious blood, and indeed bleeding – on the part of the patient, not the hygienist – is a common consequence of the gum manipulations that occur in the course of regular treatment. However, when one understands how dental hygienists actually perform their duties, and considers that ... transmission would require both a significant injury to the health care worker, despite the presence of adequate barriers, and sufficient bleeding into an open wound or mucous membrane of the patient, and the introduction of a sufficient quantity of virus to overcome the patient's natural defenses, one begins to understand why HIV transmission ... has never been detected from a hygienist to a patient....[O]ne can reasonably say that hygienist-to-patient transmission of HIV is so unlikely that it remains non-detectable and theoretical at most.

(Marianos ¶¶ 14, 15, 16(g)).

Dr. Marianos further testified that "[t]ermination of clinical duty or restriction of practice, on the basis of HIV infection alone, does not comport with accepted public health practice today, nor did it comport with accepted public health practice in 1997." (Marianos ¶21). Dr. John Molinari[5] concurs:

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[5] Dr. John Molinari is currently the Chairman and Professor at the department of Biomedical Sciences at the University of Detroit Mercy School of Dentistry. He has served as a consultant to the American Dental Association Council on Dental Therapeutic and the CDC on infection control and dentistry, the development of universal precautions,

> Taken together, the unanimity of the published studies, the characteristics of HIV, and the efficacy of universal precautions as an additional safeguard against the highly unlikely occurrence of HIV transmission to patients [by a dental hygienist], all militate against practice restrictions, not to mention mandatory termination of practice, for a HCW [health care worker] solely on the basis of his or her HIV infection.

(Molinari ¶21).

It is undisputed that HIV, a fragile pathogen, is not easily transmissible and requires a coincidence of numerous factors to cause transmission. Consequently, even when exposures involving documented modes of transmission (such as blood-to-blood contact) occur, HIV infection usually does not result. There are *no* reports in the literature of HIV transmission from a dental hygienist to a patient.

In 1991, the CDC issued a set of recommendations for management of health care workers with bloodborne diseases. *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, MORBIDITY & MORTALITY WEEKLY REPORT 1991: 40 (RR. 8): 1-9 (hereinafter "1991 Recommendations"). (R. 18, Exh. J). One of its authors was Dr. Marianos. The CDC did not identify any specific procedures that are "exposure-

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and the prevention of transmission of blood-borne pathogens, including HIV, in health care settings. He was Co-Chair of the committee that developed the State of Michigan's guidelines for management of HIV-infected health care workers. He is the co-author of the textbook, *Practical Infection Control in Dentistry* (Lea & Febinger, 2d ed. 1996). (Molinari R.19, Exh. 4 ¶1).

prone," but defined the term generally:

> Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and—if such an injury occurs—the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.

(R. 18, Exh. J at 4; *see* Marianos ¶17).

The CDC did not recommend termination of any health care worker's practice solely because of HIV infection.[6] Under the CDC guidelines, those performing what the agency characterized as "exposure-prone" procedures should appear before an expert review panel for an individualized determination as to whether and under

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[6] Dr. Witkin insisted on summary judgment that he primarily considered the 1991 Recommendations before firing Mr. Waddell (R. 21, Exh. D (Witkin Decl.), ¶2, 4). The document, however, recommends an approach wholly at odds with Dr. Witkin's reflexive action (R. 18, Exh. J). *See* Marianos Supp. Aff., ¶4-5 ("The assertion that CDC officials or employees would have advised a supervising dentist to limit the practice of, or to discharge, a dental hygienist solely because he or she was found to be HIV positive is wholly contradicted by CDC's actual position on the issue, as well as by accepted public health practice in 1997 and in the present day. . . . CDC has never advocated total removal of a functionally capable health care worker, using universal precautions, from clinical duties solely on account of HIV status. There is not now, nor was there in 1997, a perceived epidemiological basis for such an action").

what conditions he or she could continue to perform those procedures. (R. 18, Exh. J at 5).[7]

Mr. Waddell's experts also explained that health care workers' ability to practice safely primarily depends on their individual characteristics, not on the label attached to the procedures they perform. Dr. Wilber testified:

> It is the HCW's overall functional capacity, and practice history, as well as his or her knowledge of and diligence in following universal precautions, that determines whether the HCW is capable of practicing safely. Categorical decisions, based on the nature of the HCW's duties or the procedures he or she performs, are inappropriate given the variable nature of the above factors and the complete ability of a competent, diligent HCW to practice without any threat of HIV transmission.

(Wilber ¶12). *See also* Molinari ¶22.

There is no dispute in this case that Mr. Waddell is

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[7] Guidelines issued by the Georgia Division of Public Health in 1993, to which Mr. Waddell's expert Dr. Wilber was a contributor (Wilber ¶12), likewise reject *per se* exclusions from clinical practice. After reviewing the Georgia guidelines, Dr. Marianos averred that they are "squarely within the mainstream of public health theory and practice concerning HIV positive [health care workers]." (Marianos ¶22).

Dr. Marianos – an originator of the "exposure-prone procedure" concept – emphasized that Mr. Waddell does not perform exposure-prone procedures. Because proper techniques do not require the hygienist to place his hands in the patient's mouth, and because the mouth is not "considered 'poorly visualized' or confined by a hygienist accustomed to working intraorally," (Marianos ¶14), both parts of CDC's definition of the term remain unsatisfied by the routine prophylaxis techniques that Mr. Waddell is licensed to perform. (Marianos ¶19).

functionally capable of performing well as a dental hygienist. He currently provides dental hygiene services to patients of the Oral Health Center at Grady Hospital, where his supervisor rates his skills as superior (R. 19, Exh. 2 (Reznik Aff.), ¶4-5). Nor is there any dispute that Mr. Waddell scrupulously adheres to standard infection control practices. (R. 16 (Witkin Dep.), 35-37; R. 19, Exh. 2 (Reznik Aff.), ¶6; Marianos ¶9; Molinari ¶23;). All three experts testified that Valley Forge's action was contrary to accepted public health practice (Marianos ¶27; Molinari ¶23; Wilber ¶13).[8]

C. The Decisions Below

On the basis of the record described above, the district court ruled that "there is a chance that Mr. Waddell could cut or prick himself and bleed into an open wound of a patient, and reliable medical opinions state that this event can transmit the disease. For these reasons the court finds that Mr. Waddell ... presents a significant risk to the patients of the defendants." (App. A26).

The Eleventh Circuit Court of Appeals affirmed. Under the standard which the Eleventh Circuit employed, Mr. Waddell poses a "direct threat" because "when transmitting a disease inevitably entails death, the evidence supports a finding of 'significant risk' if it shows both (1)

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[8] The American Dental Association, American Dental Hygienists' Association, Infectious Diseases Society of America, Association of State and Territorial Dental Directors, National Alliance of State and Territorial AIDS Directors, HIV Medicine Association of the Infectious Diseases Society of America, American Association of Public Health Dentistry, Organization for Safety and Asepsis Procedures, American Public Health Association, and Association of Schools of Public Health also concurred in two *amici curiae* briefs to the Eleventh Circuit Court of Appeals that a dental hygienist with HIV does not pose a significant risk of transmission when normal infection control procedures are in place.

that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease." (App. A7).

Acknowledging the experts' testimony that a hygienist's fingers and a sharp instrument are rarely simultaneously in a patient's mouth, the court observed that "Waddell still is unable to refute the assertion that an inadvertent bite or some other accident during a cleaning" might lead to events that could pose a risk of transmission. (App. A12-13). The court emphasized that "[n]one of Waddell's medical experts...appear to dispute that transmission theoretically could happen, even though the risk is small and such an event never before has occurred." (App. A12). The court concluded that "[t]his is enough to constitute a significant risk..., given that HIV has catastrophic effects and is inevitably fatal if transmitted to a patient." (App. A12).

REASONS FOR GRANTING THE WRIT OF CERTIORARI

This case raises two important questions of federal law. The first is whether a vanishingly small, purely theoretical risk of serious harm, including eventual death, constitutes a "direct threat" as a matter of law under the Americans With Disabilities Act (ADA). The Eleventh Circuit's theoretical risk standard is in sharp conflict with this Court's decision in *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998), a case involving a dentist's refusal to treat a patient with HIV, where this Court recognized the guiding principle that "few, if any, activities are risk-free" and consequently that the inquiry is not "whether a risk exists, but whether it is significant." The Eleventh Circuit's approach also conflicts with decisions of other Circuits and threatens to extinguish protections against disability-based discrimination for any individual whose disability can be

theorized to pose a serious harm to others.

The second question is whether a defendant who raises a "direct threat" defense in an ADA case has the burden of proof on that defense. The Eleventh Circuit's assignment of this burden to the plaintiff reflects a sharp disagreement among the Circuits. This issue merits the Court's resolution in view of its fundamental impact on what constitutes a *prima facie* case.

I. This Court Should Grant Certiorari Because the Eleventh Circuit's Holding That As A Matter of Law An Almost Zero, Purely Theoretical Risk of Harm Resulting in Eventual Death Constitutes a Direct Threat Is in Conflict With Controlling Decisions of This Court.

The Eleventh Circuit Court of Appeals unequivocally held that, as a matter of law, any theoretically supportable theory of HIV transmission will support a "direct threat" finding under the ADA, no matter how minuscule the chance that transmission actually will occur. According to the Eleventh Circuit, "death itself makes the risk 'significant.'" 276 F.3d at 1281 (App. A7). The court's central holding finds no support in this Court's decisions.

The Americans With Disabilities Act ("ADA") provides a defense to a discrimination claim that an employee is a qualified individual with a disability when the plaintiff "pose[s] a direct threat to the health or safety of others." 42 U.S.C. § 12113(b) (Title I); 42 U.S.C. § 12182(b)(3) (Title III). The ADA defines "direct threat" in the workplace as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."

This Court first identified the appropriate standard for determining when an individual with a disability poses a

"significant risk" to others, *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), which requires:

> [findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk, (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Id. at 288. The ADA's direct threat defense is based on the standard articulated in *Arline*. *Bragdon*, 524 U.S. 624, 649 (1998).

Aware of these factors, and faced with a "direct threat" claim as Valley Forge's primary contention, Mr. Waddell independently established that his HIV had no impact on his ability to clean teeth without a measurable, significant risk of harm to patients.[9] For reasons that mirror the expert testimony in this case, knowledgeable public health officials now and in 1997, when Mr. Waddell was terminated, also rejected categorical exclusions of hygienists from continued practice solely because of HIV status.

Nonetheless, the Eleventh Circuit failed to follow

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[9] Mr. Waddell presented testimony from experts who are intimately familiar with the public health science and data that were available at the time he was fired. These experts, eminent in the fields of oral health, dental infection control, and HIV epidemiology, collectively showed that the nature of Mr. Waddell's practice, the rarity of transmission even in the event of an actual exposure, and the effective safeguards that exist virtually eliminate any theoretical risk of hygienist-to-patient transmission of HIV.

Bragdon's guidance and declined to rely on this "prevailing medical consensus," not because of "a credible scientific basis for deviating from the accepted norm," *Bragdon*, 524 U.S. at 650, but because of the failure of Mr. Waddell and his experts to prove that HIV transmission was impossible. Because "[n]one of Waddell's medical experts...appear to dispute that transmission theoretically could happen, even though the risk is small and such an event never before has occurred," the Eleventh Circuit stated, "[t]his is enough to constitute a significant risk...." 276 F.3d at 1283, (App. A12). This standard is in striking conflict with *Bragdon*, which reaffirmed that "*Arline* and the ADA do not ask whether a risk exists, but whether it is significant," and indicated that risk assessments were to be based not "on the absence of contrary evidence" but on "positive data." 524 U.S. at 649, 653.

Proper balancing of the elements of the ADA's direct threat defense contemplates that the statistical likelihood sufficient to establish a direct threat that a harm will occur will become smaller in inverse proportion to the seriousness of the harm that is risked. Nothing in the ADA or this Court's opinions, however, suggests that *any* risk of death greater than absolute zero constitutes a direct threat. Neither does the EEOC's definition of direct threat specify a particular type of risk that conclusively renders that risk significant or insignificant.[10] Removing statistical likelihood from the analysis when the harm is a potentially fatal infection is inconsistent with the four-element framework of the direct threat analysis. Indeed, the harm itself has to be "substantial" before there is even any basis to maintain the analysis should proceed to all four elements. 29 C.F.R. §

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[10] *See* 29 C.F.R. § 1630.2(r)(discrimination is not permitted "merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk, i.e., high probability of substantial harm; a speculative or remote risk is insufficient.").

1630(r). The standard applied in this case marks a result-altering departure from the standard for determining direct threat developed by this Court.

Evaluating the elements of a direct threat defense with accuracy requires recourse to science, and this Court has insisted on objective medical evidence to ensure that fears and stereotypes about contagiousness do not overwhelm federal anti-discrimination mandates. *See Arline*, 480 U.S. at 287-88. While this Court did not address directly the level of weight to be afforded the "probability" factor of the ADA standard in *Bragdon*, it did provide significant guidance as to the nature of the medical evidence required to establish, or rebut, the existence of a direct threat. After a careful analysis of the record evidence on the possibility that HIV would be transmitted in the course of providing dental care, the Supreme Court in *Bragdon* remanded the case with instructions to evaluate particular pieces of evidence before determining whether Bragdon had created an issue of material fact as to whether he faced a significant risk in providing dental care to a patient with HIV. The Court ordered remand so that risk calculations could be performed with rigor and scientific integrity, without reference to subjective, non-specific notions of risk. *See Bragdon*, 524 U.S. at 649-653.

In addressing whether the dental patient in *Bragdon* posed a "direct threat to the health or safety of others," the Court made explicit one of *Arline*'s fundamental assumptions: "Because few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant." 524 U.S. at 649. An inquiry into whether an HIV-positive patient poses a significant risk to a health care provider must "assess the level of risk," and consider the "statistical likelihood" of transmission. *Id.* at 652.

In *Bragdon*, the fact that the risk of HIV transmission was greater than zero was the backdrop for the

Court's discussion of the issue. The defendant dentist's evidence of possible transmission of HIV to seven dental workers fell short of the proof of "significant risk" that the Court demanded. *Id.* at 653. The Court's direction to "assess the level of risk," *id.* at 652, and its remand order, would have been wholly superfluous if mere proof of a theoretically recognized risk of fatality were enough to establish a direct threat. The *Bragdon* standard, if applied to the undisputed facts of this case, undoubtedly would have produced a different result.

The heart of the direct threat determination, then, involves an assessment of medical and scientific data on whether, in view of the seriousness of the harm and the statistical likelihood that the risked event will occur, that risk is significant. If medical opinion unchallenged by qualified experts concludes that a risk has almost no statistical chance of occurring, the reviewing court is without power under either the ADA or this Court's relevant decisions to discard that conclusion—no matter how serious the harm might be—because of its belief that there is some basis for finding a theoretical possibility of it happening.

Were this not the case, a host of imaginable disasters could be hypothesized to exclude virtually any individual with a disability, regardless of an individualized assessment of a particular plaintiff's impairment, skills, or specific job requirements. The Eleventh Circuit rejected evidence that a particular harm had never occurred as unimportant, *Waddell*, 276 F.3d at 1280 (App. A8), and saddled plaintiffs with the virtually impossible burden of proving that something that never has happened won't occur in the future.

Consequently, the Eleventh Circuit's analysis has implications far beyond health care assistants such as Mr. Waddell. It threatens to insulate from challenge virtually any discrimination against persons with disabilities in employment, health care, education, and every other aspect of community life. To prevail, all an employer must argue is

that the plaintiff's disability poses some imaginable, non-zero risk of a catastrophic occurrence resulting in possible death. *Waddell's* reasoning permits, for example, an employer's refusal to hire an HIV positive applicant for an office job because of the remote risk that she might cut herself on a staple and expose a co-worker to her blood, a scenario impossible to definitively disprove. A teacher with HIV also would be unable to prove that no child in her classroom is capable of suddenly seizing his arm, biting it, and having the sufficient confluence of blood, high viral load and breaks in the skin of the mouth to accomplish the statistically extremely unlikely event of HIV transmission. A firefighter with hepatitis C can not prove that, in the course of a rescue, he will never be unable to use infection control equipment on a victim in need of resuscitation and that it will be impossible to transmit his disease. A wheel-chair bound day care manager could not prove that he will never be needed to assist a worker in getting children out of a building in the case of a fire and that nothing will interfere with his ability to do that.

Bragdon applied a four-prong test that demands positive evidence on each prong; the Eleventh Circuit applied a different standard altogether. The dissonance of the Eleventh Circuit's approach is perhaps most apparent in the context of *Bragdon* itself. Application of the Eleventh Circuit's theoretical-risk standard to the record in *Bragdon*, which included known reports on documented HIV transmissions from patient to health care worker, coupled with an ability to hypothesize events producing a scientifically sound, if theoretical, possibility of infecting Dr. Bragdon, would have produced the result that as a matter of law Sydney Abbott posed a direct threat, rendering a remand unnecessary.

II. This Court Should Grant Certiorari Because the Eleventh Circuit's Opinion Increases the Confusion Among the Courts of Appeals As To Whether A Purely Theoretical Risk of Serious Harm, Including Death, Is Sufficient to Constitute A Direct Threat As A Matter of Law.

The Eleventh Circuit's approach marks not only a parting from this Court's opinions, but also reflects a larger disagreement among the Circuits on how risk should be quantified under the ADA when the harm at issue poses potentially fatal consequences. In their most recent rulings on the issue, the Eleventh and Fourth Circuits have concluded that any risk of death, however remote and speculative, is significant, while the First, Fifth, Sixth, and Ninth have declined to find that even the risk of death is significant if the probability that it will occur is extremely small.[11]

Similar to the Eleventh Circuit's approach, the Fourth Circuit weighted the factor of harm from HIV infection to such a degree that *any* risk that death or

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[11] As discussed below, the Sixth Circuit's most recent ruling on this issue rejects a "no theoretical risk" application of the *Arline* standard. In an earlier case involving an HIV positive surgical assistant, however, the Sixth Circuit found in the context of considerable testimony from both parties that evidence of an extremely small probability of occurrence is sufficient as a matter of law when the possible transmission of HIV was involved. *See Estate of Mauro v. Borgess Med. Ctr.*, 137 F.3d 398, 405, 407 (6th Cir. 1998) (affirming summary judgment against surgical technician despite evidence that employee rarely had his fingers in the vicinity of a surgical incision, and even though CDC estimated the odds of transmission from a surgeon to a patient as in the 1 in 42,000 to 1 in 420,000 range). Consequently, it is unclear whether the Sixth Circuit's more recent decision in *Hamlin v. Charter Township of Flint*, 165 F.3d 426 (6th Cir. 1999) reflects its current view of the appropriate standard in all cases, or the fact that serious infectious disease prompts application of a more exacting (and inappropriate) test.

transmission will occur, even if never previously documented in the setting at issue, is sufficient basis for a finding of direct threat. In *Montalvo v. Radcliffe*, 167 F.3d 873 (4th Cir. 1999), *cert denied*, 528 U.S. 813 (1999), addressing the exclusion of an HIV positive child from a group karate class, the court found that because of the mere theoretical *possibility* of HIV infection "from blood splashing into the eyes or onto seemingly intact skin," the youngster posed a direct threat to other children. 167 F.3d at 877-78. The court never addressed the *statistical likelihood* of whether HIV can be transmitted through blood contact during athletic activity.[12]

In contrast, as this court noted, "for the most part" the First Circuit Court of Appeals in the initial *Bragdon* appeal "followed the proper standard in evaluating the petitioner's position and conducted a thorough review of the evidence." 524 U.S. at 650. In *Bragdon v. Abbott*, 163 F.3d 87 (1st Cir. 1998)(decision after remand), *cert. denied*, 526 U.S. 1131 (1999), 119 S.Ct. 1805 (1998), the First Circuit again rejected a dentist's argument that providing routine dental care to a patient with HIV created a direct threat to himself and others. The defendant dentist in that case had presented expert evidence to support his position and relied principally on forty-two documented cases of HIV transmission from patients to health care workers, seven cases of "possible" HIV transmission from patients to dental workers, and a CDC report of likely transmission from a dentist to six patients.

In its first decision, the First Circuit had found that this evidence was not sufficient to create a triable factual

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[12] In fact, the Centers for Disease Control and Prevention (CDC) reports that "[t]here are no documented cases of HIV transmitted during participation in sports." Centers for Disease Control and Prevention, *HIV/AIDS Prevention Update* (Nov. 30, 1998), http://dvd.gov.nchstp/hiv_aids/pubs/faq/faq30.htm (visited June 18, 1999).

issue of the existence of "significant risk," assessing each piece of evidence in turn as not comparable to the setting and personnel at issue, as "too speculative," or as failing to "quantitate the risk of HIV transmission." *See Abbott v. Bragdon*, 107 F.3d 934, 946, 947 (1st Cir. 1997), *aff'd in part, vacated and remanded in part*, 524 U.S. 624 (1998). On remand, the First Circuit reexamined the evidence according to this Court's direction, and readopted its previous holding:

> We previously held that [the evidence of documented and possible cases of HIV transmission in the health care setting] was insufficient without a documented showing that the risks to dentists and other health-care workers are comparable, *see* 107 F.3d at 947, and the appellant offers us no cogent reason to change our view...Our assessment of Dr. Bragdon's, and his amici's, other reprised arguments similarly remains unchanged. Each piece of evidence to which they direct us is still "too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact." *Id.* At 948.

Bragdon v. Abbott, 163 F.3d at 90.

The Fifth Circuit, in *Rizzo v. Children's World Learning Ctrs.*, 84 F.3d 758 (5th Cir. 1996), also applied the four-prong direct threat test in a manner that took into account the factor of the probability that harm, including death, could occur. Reversing a decision to remove a hearing-impaired employee from her school van driving responsibilities on the basis that she might not hear a choking child in the back of the bus, the court acknowledged that any risk of harm to children "will greatly impact the consideration of '[t]he nature and severity of the potential

harm,'" 84 F.3d at 764. However, the Fifth Circuit held that the lower court had not properly considered whether the harm in question was *significantly likely* to occur. *Id.* The Court remanded the case for a trial on whether the school could in fact establish that Rizzo's relative abilities to hear and respond to a choking child in fact made her a direct threat to the children she transported.

In *Hamlin v. Charter Township of Flint*, 165 F.3d 426 (6th Cir. 1999), the Flint Township Fire Department defended its termination of Hamlin, a firefighter, after he had suffered a heart attack and had to avoid strenuous physical activities by arguing that Hamlin posed a direct threat as a consequence of his physical inability to engage in active firefighting duties. Flint pointed to the unpredictability of a firefighter's work environment, and the possibility that the "first responder" to a scene might be needed to rescue someone trapped inside a building. The Sixth Circuit Court of Appeals rejected this line of reasoning, stating that it is a violation of the ADA to deny an opportunity to a person with a disability "merely because of a slightly increased risk":

> The risk can only be considered when it poses a significant risk, i.e., a *high probability* of substantial harm; *a speculative or remote risk is insufficient.* Flint failed to show that there was " a high probability of potential harm...or that the alleged risk was anything more than speculative or remote."

Id. at 432.

The Eleventh Circuit's application of *Arline* and *Bragdon* also conflicts with that of the Ninth Circuit in *Chalk v. United States Dist. Court*, 840 F.2d 701, 709 (9th Cir. 1988). Applying the *Arline* test to a Rehabilitation Act case, the court held that "it was error to require that every

theoretical possibility of harm be disproved." *Chalk* held that a schoolteacher with AIDS should not have been removed from the classroom because he did not pose any real risk to his students. While acknowledging that the risk that the teacher would transmit HIV to any student was minimal, the district court had concluded that the risk nonetheless was "significant" because of the severe consequences of infection. Reversing, the Ninth Circuit found that the district court had failed to follow *Arline* by discounting scientific evidence that the likelihood of transmission was very slight. 840 F.2d at 708-09.

Several years after this Court's decision in *Bragdon*, the lower courts interpret the four-prong direct threat standard in a manner that effectively ensures that the same plaintiff with the same facts can expect very different outcomes depending on the circuit in which he finds himself, revealing a lack of clarity with significant consequences that this Court should address.

III. Certiorari Also Is Necessary to Resolve The Conflict Among the Courts of Appeals As To Which Party Bears the Burden of Proof On A Direct Threat Defense.

Most of the Courts of Appeals have addressed the issue of which party bears the burden of proof on the existence of a direct threat under the ADA; what has emerged is a confusing divergence of opinion on the proper interpretation of a central part of the statute. With many of these cases resolved on summary judgment, the resolution of this dispute is of critical importance to parties with ADA claims, and one that requires this Court's intervention.

The Circuits' handling of the burden of proof on direct threat reveals confusion on a matter that affects the threshold issue of what constitutes a plaintiff's *prima facie* case. The Eleventh Circuit in this case, *see* 276 F.3d at

1280, and the First Circuit, in *EEOC v. Amego, Inc.*, 110 F.3d 135 (1st Cir. 1997) place the burden on the plaintiff as part of a *prima facie* case demonstrating that the plaintiff with a disability also is qualified. Taking the opposing view that, consistent with the position of the EEOC, places the burden of proving a direct threat defense squarely on the employer are the Fifth Circuit, *see Rizzo v. Children's World Learning Ctrs., Inc.*, 213 F.3d 209 (5th Cir. 2000); the Seventh Circuit, *see Dadian v. Vill. of Wilmette*, 269 F.3d 831 (7th Cir. 2001); *EEOC v. AIC Sec. Investigations, Ltd.*, 55 F.3d 1276 (7th Cir. 1995); the Eighth Circuit, *see Stafne v. Unicare Homes*, 266 F.3d 771 (8th Cir. 2001); the Ninth Circuit, *see Hutton v. Elf Atochem N. America, Inc.*, 273 F.3d 884 (9th Cir. 2001); and the Tenth Circuit, *see Hartog v. Wasatch Acad.*, 129 F.3d 1076 (10th Cir. 1997).

The confusion as to which party must establish the presence or absence of a direct threat, and as basic a question as what burdens of proof an ADA plaintiff must assume in making a *prima facie* case, impair the ability of parties to an ADA case to litigate their claims in an effective and efficient matter. The Court should grant *certiorari* to resolve this unpredictability in a fundamental aspect of the statute.

CONCLUSION

For the reasons set forth above, the petition for writ of *certiorari* should be granted.

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Dated: March 21, 2002

APPENDIX

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 00-14896

D.C. Docket No. 99-00262-CV-CAP-1

SPENCER WADDELL,

Plaintiff-Appellant,

v

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Georgia

(December 21, 2001)

Before BIRCH, MARCUS and WOOD[1], Circuit Judges.
BIRCH, Circuit Judge:

Spencer Waddell appeals the district court's order

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[1] Honorable Harlington Wood, U.S. Circuit Judge for the Seventh Circuit, sitting by designation.

granting summary judgment to the defendant, Valley Forge Dental Associates, Inc., on his discrimination claims under the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101 et seq., and the Rehabilitation Act, 29 U.S.C. § 701 et seq. This case requires us to decide whether the district court properly held that Waddell, an HIV-positive dental hygienist, was not otherwise qualified for his employment position because he posed a direct threat to his patients. We AFFIRM.

I. BACKGROUND

Waddell, a dental hygienist licensed by the State of Georgia, was employed by Dr. Eugene Witkin from early 1996 until October 1997. In February 1997, Valley Forge took over Witkin's practice. Under this agreement, Witkin and his employees became Valley Forge's employees.[1] Waddell's primary responsibility as a dental hygienist for both Witkin and Valley Forge was the performance of routine prophylaxis, or, in lay terms, the cleaning of teeth.

In September 1997, Dr. Sourignamath Bhat administered a test to Waddell to determine whether he carried the human immunodeficiency virus ("HIV"). Waddell's test results indicated that he was HIV-positive. Bhat telephoned Witkin to inform him of Waddell's test results, and Witkin in turn alerted Jill Whelchel, a dental hygienist and administrator at Valley Forge, to Waddell's status. Whelchel contacted Jean Welsko in Valley Forge's Human Resources Department and sought advice on how to

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[1] Subsequent to Waddell's disassociation from the practice, Monarch Dental Associates acquired Valley Forge and became its successor-in-interest. For the sake of convenience, we will refer to the Defendant-Appellee as "Valley Forge."

handle the situation. On Welsko's suggestion, Witkin and Whelchel met with Waddell and put him on paid leave until the three of them could decide what action should be taken. During the next week, Witkin studied his stockpile of dental journals to glean information about the transmission of HIV in the dental context. The Centers for Disease Control and Prevention ("CDC") also was consulted concerning the risk of transmission. Witkin and Whelchel then met with Waddell again and told him that he could no longer treat patients because of his HIV-positive status. They offered Waddell a clerical job at the front desk at roughly half of the salary he had made as a dental hygienist. Waddell took another week off to consider the proposition, and when he ultimately refused to accept the offered job at the offered rate of pay, Valley Forge terminated his employment.

Waddell brought this suit against Valley Forge, seeking relief under the ADA, the Rehabilitation Act, and various Georgia statutory provisions. After conducting discovery, both Waddell and Valley Forge moved for summary judgment. The issues on the ADA claim were limited by the fact that Valley Forge admitted that its decision to remove Waddell from his position as a dental hygienist was based solely on his HIV-positive status. The bulk of the evidence presented in support of the summary judgment motions addressed the question of whether Waddell's HIV-positive status made him a direct threat to dental patients, which would preclude him from demonstrating that he was qualified to perform the duties of a dental hygienist. See 42 U.S.C. § 12113(b). The district court found that Waddell's job entailed "exposure-prone" procedures as that term has been defined by the CDC, and that the necessity of performing the procedures made Waddell a direct threat under the standard we set forth in Onishea v. Hopper, 171 F.3d 1289, 1299 (11th Cir. 1999) (en

banc). Consistent with this finding, the district court denied Waddell's motion for summary judgment and instead granted summary judgment in favor of Valley Forge.[2] Waddell appeals the district court's ruling on both summary judgment motions.

II. DISCUSSION

We review the district court's decision to grant summary judgment de novo, and in so doing we apply the same legal standards that were applicable in the trial court. See Hilburn v. Murata Elecs. N. Am., Inc., 181 F.3d 1220, 1225 (11th Cir. 1999). "Summary judgment is proper if the pleadings, depositions, and affidavits show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." Pritchard v. Southern Co. Servs., 92 F.3d 1130, 1132 (11th Cir. 1996); see also Fed. R. Civ. P. 56(c). There is a genuine issue of material fact if the nonmoving party has produced evidence such that a reasonable factfinder could return a verdict in its favor. Patterson & Wilder Constr. Co. v. United States, 226 F.3d 1269, 1273 (11th Cir. 2000).

In order to establish a prima facie case of discrimination under the ADA, Waddell "must demonstrate that [he] (1) is disabled, (2) is a qualified individual, and (3) was subjected to unlawful discrimination because of [his] disability." Cash v. Smith, 231 F.3d 1301, 1305 (11th Cir.

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[2] The district court granted summary judgment for Valley Forge on Waddell's Rehabilitation Act claim on the ground that Waddell had produced no evidence that Valley Forge receives financial assistance from the federal government. Having granted Valley Forge summary judgment on all of Waddell's federal claims, the district court declined to exercise pendent jurisdiction over Waddell's state-law claims.

2000); see also 42 U.S.C. § 12112(a).[3] As they did in the district court, the parties on appeal focus their arguments on whether Waddell is a qualified individual under § 12112(a).[4]

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[3] Waddell appeals the summary judgment on his Rehabilitation Act claim on the same grounds that he appeals the summary judgment on his ADA claim. The district court, however, granted summary judgment on the two claims for different reasons. Because Waddell does not address the district court's rationale for granting summary judgment on his Rehabilitation Act claim, we deem his appeal on that issue waived. In any event, because we evaluate claims brought under the Rehabilitation Act and the ADA under the same standards, Sutton v. Lader, 185 F.3d 1203, 1207-08 n.5 (11th Cir. 1999), our conclusion that Waddell is not otherwise qualified for his employment position is fatal to both his Rehabilitation Act and ADA claims.

[4] Valley Forge also argues that Waddell has failed to establish that he is disabled because his asymptomatic HIV does not substantially limit one of his major life activities and because HIV is not a disability per se . See 42 U.S.C. § 12102(2)(A). Waddell alleges in his pleadings that HIV has substantially limited his intimate and sexual relationships, his participation in societal and community life, his ability to plan his life and care for himself, and his ability to travel. Even if we assume that these constitute major life activities, we cannot determine whether Waddell is substantially limited as to any of these, given that we have before us such a skeletal record on the issue.

As to the disability per se issue, we recognize that some of our past cases suggest in dicta that HIV should be treated as a per se disability. See, e.g., Doe v. Dekalb County Sch. Dist., 145 F.3d 1441, 1445 n.5 (11th Cir. 1998). We note, however, that in Bragdon v. Abbott, the Supreme Court declined to address whether asymptomatic HIV is a per se disability, arguably suggesting, at least implicitly, that the preferred method is to address whether an impairment causes a substantial limitation upon a major life activity on a case-by-case, individualized basis. 524 U.S. 624, 641-42, 118 S. Ct. 2196, 2207 (1998). Two recent cases further demonstrate that the Supreme Court favors an individualized analysis. See Albertson's, Inc. v. Kirkingburg, 527 U.S. 555, 119 S. Ct. 2162 (1999); Sutton v. United Airlines, Inc., 527 U.S. 471, 119 S. Ct. 2139 (1999). Nevertheless, we need not address whether Waddell is disabled, either on the theory that he is substantially limited in a major

Specifically, the parties debate whether the risk of Waddell transmitting HIV to a patient in the course of treatment poses a direct threat to others in the workplace. See 42 U.S.C. § 12111(3). Waddell carries the burden of establishing that "he was not a direct threat or that reasonable accommodations were available." LaChance v. Duffy's Draft House, Inc., 146 F.3d 832, 836 (11th Cir. 1998). If he cannot meet this burden, he is not a qualified individual and therefore cannot establish a prima facie case of discrimination.

The term "direct threat" is defined as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation." 42 U.S.C. § 12111(3). Addressing this issue, the Supreme Court explained in School Board of Nassau County v. Arline that "[a] person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk." 480 U.S. 273, 287 n.16, 107 S. Ct. 1123, 1131 n.16 (1987). To determine whether an employee who carries an infectious disease poses a significant risk to others, the Supreme Court has stated that courts should consider several factors, which include:

> [findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk, (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and

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life activity or on the theory that HIV is a disability per se. Because we agree with the district court that Waddell is not a qualified individual under the ADA, we do not reach the disability issue.

will cause varying degrees of harm.

Id. at 288, 107 S. Ct. at 1131 (citation omitted). The Supreme Court also has indicated that an employer in the medical field, "[a]s a health care professional, . . . ha[s] the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession," Bragdon, 524 U.S. at 649, 118 S. Ct. at 2210, and that his employment decision concerning an infected employee must be "reasonable in light of the available medical evidence," irrespective of whether his decision was made in good faith, id. at 650, 118 S. Ct. at 2211. See also Lowe v. Alabama Power Co., 244 F.3d 1305, 1308 (11th Cir. 2001) (noting "that a good-faith belief that a significant risk of harm exists is insufficient if it is not grounded in medical or other objective, scientific evidence").

We have not had occasion to apply the significant risk analysis enunciated in Arline and Bragdon to a case involving an HIV-positive employee in the medical field, as is the situation here. In Onishea, however, even though the facts did not involve an employee in the medical field, the disability at issue was HIV infection, and in that case we elaborated on the meaning of "significant risk," holding that "when transmitting a disease inevitably entails death, the evidence supports a finding of 'significant risk' if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease." 171 F.3d at 1299. We noted that "when the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low: death itself makes the risk 'significant.'" Id. at 1297. Moreover, we emphasized that although the "asserted danger of transfer must be rooted in sound medical opinion and not be speculative or fanciful[,] . . . this is not a

'somebody has to die first' standard, either: evidence of actual transmission of the fatal disease in the relevant context is not necessary to a finding of significant risk." Id. at 1299.

Applying these principles to the case at hand, we conclude that the record establishes that the district court properly granted summary judgment to Valley Forge because an HIV-infected dental hygienist like Waddell poses a significant risk of HIV transmission to his patients. The district court concluded that Waddell posed a significant risk based on the two-part test we delineated in Onishea, 171 F.3d at 1299. The court found that a certain event could occur — a dental hygienist like Waddell could cut or prick his finger while performing a procedure in a patient's mouth, and the hygienist's blood then could come into contact with an oral cut or abrasion. The court also found that the procedures used to clean teeth were "exposure- prone" based on the CDC definition of that term,[5] and therefore that reliable

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[5] In 1991, the CDC issued a set of recommendations for management of healthcare workers infected with HIV or Hepatitis B. With reference to exposure-prone procedures, the recommendations state:

> Characteristics of exposure-prone procedures include . . . the simultaneous presence of the HCW's [healthcare worker's] fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury [skin piercing] to the HCW, and – if such an injury occurs — the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.

Centers for Disease Control and Prevention, Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, Morbidity & Mortality Weekly Report 4 (1991) (R2-18 Exh. J).

medical opinion indicated that if the certain event occurred, Waddell could expose a patient to HIV.

In reaching these conclusions, the district court considered the four factors laid down in Arline, 480 U.S. at 288, 107 S. Ct. at 1131. As to the first factor, the nature of the risk, the district court found that HIV is transmitted when infected blood or other bodily fluids come into contact with the blood, mucous membrane, or other fluids of another person. Neither party on appeal contests this issue, and both parties agree that any risk of HIV transmission in the dental setting would arise from contact between Waddell's blood and an open wound or mucous membrane of a patient.

As to the second factor, the duration of the risk, the court found that HIV infection is indefinite because there is no cure for HIV at this time. Again, both parties agree on this point. As to the third factor, the severity of the risk to third parties, the court found that the potential harm to a person infected is eventual death. Although in this litigation Waddell attempted to downplay the effects of HIV infection on the individual, the court's conclusion on this point appears incontrovertible, especially since Waddell himself admits that there is no current cure for HIV infection. See also Bragdon, 524 U.S. at 633-37, 118 S. Ct. at 2203-04 (discussing the unalterable and catastrophic consequences of HIV infection on the individual).

At the heart of this case, however, is the district court's analysis of the fourth factor delineated in Arline, the probability of HIV transmission between a dental hygienist and patient. The court noted that because Waddell performed some procedures that entailed the use of sharp instruments, there was a risk that he could cut or prick himself and bleed into an open wound or abrasion in the patient's mouth.

Although the court determined that the likelihood of transmission from a healthcare worker to a patient was low, the court found that there was a sound, theoretical possibility that Waddell could transmit HIV to a patient. For this reason, the court concluded that based on our definition of significant risk in Onishea, 171 F.3d at 1299, Waddell posed a direct threat to patients at his workplace and thus was not a qualified individual under the ADA.

Even though Waddell and his experts downplay the procedures Waddell had to perform as a dental hygienist and argue that these procedures are not exposure-prone, we agree with the district court's analysis for several reasons. The uncontroverted evidence establishes that dental cleaning procedures involve the use of sharp objects. In his deposition, Waddell noted that a normal teeth cleaning entailed the performance of "scaling" and "root planing" on the patient. Scaling involves the removal of material from teeth at points above the gumline, and root planing involves the removal of material below the gumline. One of Waddell's medical experts, Dr. Donald Marianos, indicated that scaling involves the use of a sharp instrument. For the root-planing procedure, Waddell stated that he would use "a dental instrument designed with a single blade to cut towards [the] working surface." Waddell Dep. at 29 (R4-34).

The unrebutted evidence also shows that during routine procedures like scaling and root planing, blood of the patient is commonly present. Waddell, in his own deposition, noted that during the scaling procedure, the patient's blood was present in "most" cases. Id. at 28. He noted that during the root-planing procedure, "there should always be" blood of the patient present. Id. at 29. Indeed, in his appellant brief, Waddell acknowledges that "patient bleeding during a routine dental checkup is a common

experience." Appellant Br. at 33.

The combination of sharp instruments used by the hygienist and a patient's blood commonly being present indicate that the hygienist could cut or prick himself with such an instrument, pierce the skin of his protective glove, and transfer his blood into the patient's mouth, where it would come into contact with an oral cut or abrasion. In fact, the uncontroverted evidence establishes that a dental worker sometimes does stick or cut himself or herself during treatment. For instance, Waddell related that one time when he was performing scaling work on a patient, he turned away from the patient to replace the scaler tip. The scaler tip broke and scratched his skin, and he had to take a break to ensure that the bleeding had stopped and to bandage the site. Valley Forge dental hygienist and administrator, Whelchel, also told in her deposition of an incident that occurred when she was cleaning teeth. She stated that while she was using an instrument on a patient, the tip cut the skin of her finger, which was inside the patient's mouth and near the tongue.

It is true that there is some dispute between the parties as to how often a dental hygienist's fingers are present in a patient's mouth at the same time as sharp instruments. Waddell's own objective medical evidence on this point, however, indicates that a hygienist's fingers are in a patient's mouth along with a sharp instrument at least some of the time. For example, Dr. Marianos, one of Waddell's medical experts, stated that a hygienist's fingers and dental instruments are "rarely," in the patient's mouth at the same time. Marianos Aff. at 5 (R3-27). By negative implication, of course, Marianos's statement suggests that at least in some instances, both finger and instrument are in the patient's mouth simultaneously.

In addition, it is important to note that Waddell and his experts in fact acknowledge that there is a possibility of blood-to-blood contact between hygienist and patient, irrespective of precisely how often a hygienist's fingers are in a patient's mouth alongside a sharp instrument. For instance, while Waddell notes in his appellant brief that the exposure of a patient to HIV will not occur during routine procedures, he concedes that "[p]ercutaneous . . . injuries resulting in blood-to-blood contact theoretically provide opportunities for transmission." Appellant Br. at 36. None of Waddell's medical experts, moreover, appear to dispute that transmission theoretically could happen, even though the risk is small and such an event never before has occurred. This is enough to constitute a significant risk under Onishea, given that HIV has catastrophic effects and is inevitably fatal if transmitted to a patient. In Onishea, we agreed with the Fourth, Fifth, and Sixth Circuits that:

> a showing of a specific and theoretically sound means of possible transmission [is] enough to justify summary judgment against an HIV-positive plaintiff on the ground that the infection pose[s] a 'significant risk' to others in the workplace, even though reported incidents of transmission [are] few or nonexistent, and the odds of transmission [are] admittedly small.

171 F.3d at 1297. The district court's grant of summary judgment to Valley Forge is consistent with this language because even a small and "theoretically possible method of [HIV] transmission" from Waddell to a patient — a risk that even Waddell's medical experts acknowledge — can create a significant risk under the ADA because transmission, if it occurs, is fatal. Id. at 1299.

We also point out that even if there remains some

question as to how often Waddell's hand would be in a patient's mouth at the same time as a sharp instrument, Waddell still is unable to refute the assertion that an inadvertent bite or some other accident during a cleaning could lead to the mixture of Waddell's blood with a patient's blood due to an oral cut or abrasion. Indeed, the CDC has noted that with regard to dentistry, "trauma," in one form or another, "to health-care workers' hands is common." Centers for Disease Control and Prevention, Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings, Morbidity & Mortality Weekly Report 379 (1988) (R2-18 Exh. K). For example, a child patient (or even an adult) could bite down on a hygienist's finger in a moment of fear, pain, anger, or surprise, causing blood to be transmitted into the child's (or adult's) mouth. Waddell himself, in fact, acknowledged in his deposition that he had heard of dental hygienists who had been bitten by patients.

In summary, several factors, when taken together, indicate that Waddell poses a significant risk to others in the workplace: the use of sharp instruments by dental hygienists; routine patient bleeding during dental work; the risk that hygienists will be stuck or pricked while using an instrument; the statements of Waddell and medical his experts acknowledging that there is some risk, even if theoretical and small, that blood-to-blood contact between hygienist and patient can occur; and the possibility of an inadvertent bite or other accident during a dental cleaning. These "particularized facts" provide "the best available objective evidence" that Waddell, because he is infected with the fatal, contagious disease of HIV, is a direct threat to his workplace, and therefore not a qualified individual under the ADA. Lowe, 244 F.3d at 1309.

III. CONCLUSION

In this appeal, Waddell has argued that the district court erred in denying his motion for summary judgment on his claims under the ADA and the Rehabilitation Act and in granting Valley Forge's summary judgment motion. We have decided that the district court was correct in finding that there was no genuine issue of material fact and that Valley Forge was entitled to judgment as a matter of law on the issue of whether Waddell was a qualified individual. Waddell never controverted the fact that if a certain event occurred — a cut or abrasion to the finger of Waddell while performing dental procedures in a patient's mouth caused by a sharp instrument, an inadvertent bite, or some other accident — there was a specific, theoretically sound possibility of transmission. Because there was such a possibility of transmission, the risk involved, in light of Onishea, was significant due to the fatal nature of HIV. Accordingly, we AFFIRM.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

SPENCER WADDELL,
Plaintiff,

CIVIL ACTION NO.
1:99-CV-0262-CAP

v.

VALLEY FORGE DENTAL ASSOCIATES, INC., AND JOHN DOE, as successor-in-interest of VALLEY FORGE DENTAL ASSOCIATES, INC.,
Defendants.

ORDER

The plaintiff filed the instant action, alleging he was terminated by Valley Forge Dental Associates, Inc. ("Valley Forge") in violation of the Americans with Disabilities Act ("ADA"), the Rehabilitation Act ("Rehab Act"), O.C.G.A §§ 34-6A-1 et seq., and 30-1-2. Mr. Waddell also asserts a claim for breach of a legal duty under Georgia Law. This matter is before the court on the defendants' motion for summary judgment [Doc. No. 18-1], the plaintiff's motion for partial summary judgment [Doc. No. 19-1], as well as several other motions involving expert witnesses. There is also a motion by the plaintiff for leave to file a brief in excess of page limits [Doc. No. 23-1].

The plaintiff's motion for leave to file his brief in excess of page limits [Doc. No. 23-1] is hereby GRANTED.

Expert Witness Motions

As a preliminary matter, the court hereby GRANTS the plaintiff's motion to substitute the affidavit of Donald Marianos [Doc. No. 27-1], which MOOTS the plaintiff's similar motion to substitute [Doc. No. 24-1].

In their motions to strike the plaintiff's experts' affidavits [Doc. No. 22-1] and to strike the supplemental affidavit of Donald Marianos [Doc. No. 32-1], the defendants object to the affidavits because they contend that the reports filed by the plaintiff pursuant to Fed.R.Civ.P. 26(a) (2) were insufficient in that the reports did not include all of the opinions that were contained in the subsequent affidavits. The defendants contend that based on these reports, they chose not to depose the plaintiff's experts. While the court finds that the reports were not as explicit as they could have been, the defendants were certainly on notice that these experts were going to provide testimony relevant to this case and should have deposed them during discovery. Therefore, the defendants' motions to strike the plaintiff's experts' affidavits [Doc. Nos. 22-1; 32-1] is DENIED.

The plaintiff has also moved to strike the defendants' expert [Doc. No. 26-1]. The plaintiff contends that the testimony of Dr. Harris, the defendant's expert, should not be allowed because he was not named until very late in discovery. The court finds that because the defendants did not receive all of the plaintiff's expert reports until late in discovery, the defendants were justified in not naming their expert sooner. Therefore, the plaintiff's motion to strike the defendants' expert is hereby [Doc. No. 26-1] DENIED.

Summary Judgment Motions

Currently pending before the court are the defendants' motion for summary judgment [Doc. No. 18-1] and the

plaintiff's motion for partial summary judgment [Doc. No. 19-1]. In analyzing a summary judgment motion, the court resolves all issues of fact in favor of the non-movant. See Cottrell v. Caldwell, 85 F.3d 1480 (11th Cir. 1996). Here, because both parties have moved for summary judgment and the court finds in favor of the defendant, it states the facts of the case in the light most favorable to the plaintiff. Therefore, the facts, as stated below, may not prove to be the facts that would be established at trial. See Hartsfield v. Lamacks, 50 F.3d 950, 951 (11th Cir. 1995) (citing Rodgers v. Horsley, 39 F.3d 308, 309 (11th Cir. 1994)).

FACTUAL DISCUSSION

The claims in this case arise from the termination of the plaintiff, Spencer Waddell, by defendant Valley Forge Dental Associates, Inc.[6] Mr. Waddell is a dental hygienist who was employed by the defendants from 1993 until October 1997. Sometime in 1995, Mr. Waddell temporarily left the employ of the defendants, but returned in 1996.

In September 1997, Mr. Waddell underwent an HIV test, which was performed by Dr. Sourignamath Bhat. The test results revealed that Mr. Waddell was infected with the human immunodeficiency virus (HIV), the virus that causes AIDS. At all relevant times, Mr. Waddell's condition has been asymptomatic. Dr. Bhat phoned Dr. Eugene Witkin, the defendants' regional director and Mr. Waddell's supervisor, to inform him that Mr. Waddell had tested positive for HIV.

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[6] The case was originally styled with Valley Forge as one defendant and John Doe, as successor-in-interest of Valley Forge, as the other defendant. In the plaintiff's motion for partial summary judgment, the plaintiff identifies Monarch Dental Associates as the successor-in-interest. The court will use the term "defendants" to refer to Valley Forge Dental Associates, Inc. and Monarch Dental Associates.

Dr. Witkin informed Jill Whelchel, an administrator for the defendants, of Mr. Waddell's condition. Ms. Whelchel then informed the defendants' Human Resources department.

On September 29, 1997, Mr. Waddell was told that he was being put on a temporary leave of absence while the defendants considered his employment status. Dr. Witkin and Ms. Whelchel sought information on HIV and HIV transmission related to dental hygienists. They also sought legal advice from the defendants. On October 10, 1997, based on the information he obtained and, presumably, on the legal advice he received via the defendants, Dr. Witkin told Mr. Waddell that he would no longer be allowed to treat patients. Dr. Witkin offered him a non-clinical, clerical position at a lower salary, which Mr. Waddell declined. The defendants considered this a resignation and terminated Mr. Waddell's employment. Mr. Waddell, believing he was terminated in violation of his rights under the ADA and the Rehab Act, as well as several state statutes, brought this action.

LEGAL ANALYSIS

Rule 56(c) of the Federal Rules of Civil Procedure authorizes summary judgment when all "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show there is no genuine issue as to any material fact and...the moving party is entitled to judgment as a matter of law." The party seeking summary judgment bears the burden of demonstrating that no dispute as to any material fact exists. Adickes v. S.H. Kress & Co., 398 U.S. 144, 156, 90 S.Ct. 1598, 1608 (1970); Johnson v. Clifton, 74 F.3d 1087, 1090 (11th Cir. 1996). The moving party's burden is discharged merely by "'showing' -- that is, pointing out to the District Court that

there is an absence of evidence to support [an essential element of] the nonmoving party's case." Celotex Corp. v. Catrett, 477 U.S. 317, 325, 106 S.Ct. 2548, 2554 (1986). In determining whether the moving party has met this burden, the district court must view the evidence and all factual inferences in the light most favorable to the party opposing the motion. Clifton, 74 F.3d at 1090. Once the moving party has adequately supported its motion, the nonmovant then has the burden of showing that summary judgment is improper by coming forward with specific facts showing a genuine dispute. Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574, 586, 106 S.Ct. 1348, 1356 (1986).

In deciding a motion for summary judgment, it is not the court's function to decide issues of material fact but to decide only whether there is such an issue to be tried. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 251, 106 S.Ct. 2505, 2511 (1986). The applicable substantive law will identify those facts that are material. Anderson, 477 U.S. at 247, 106 S.Ct. at 2510. Facts that in good faith are disputed, but which do not resolve or affect the outcome of the case, will not preclude the entry of summary judgment as those facts are not material. Id.

Genuine disputes are those by which the evidence is such that a reasonable jury could return a verdict for the nonmovant. Id. In order for factual issues to be "genuine" they must have a real basis in the record. Matsushita, 475 U.S. at 586, 106 S.Ct. at 1356. When the record as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial." Id. (citations omitted).

Mr. Waddell's Claim Under the Rehab Act

One of Mr. Waddell's claims for discrimination is brought under the Rehab Act, 29 U.S.C. § 791 et seq. The statute states in relevant part:

> No otherwise qualified individual with a disability in the United States...shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....
> 29 U.S.C. §794(a)

Mr. Waddell contends that the defendants receive Federal financial assistance in the form of Medicaid and Medicare payments. The only evidence which he cites is his own affidavit. See Waddell Affidavit ¶ 6 Attached to the Plaintiff's Brief in Support of his Motion for Partial Summary Judgment. However, Mr. Waddell has not alleged that he had any knowledge of the billing practices of the defendants. Conversely, the defendants have offered a declaration by Jill Whelchel, the individual responsible for patient billing at the defendants' office, that the defendants do not accept Medicaid or Medicare. The court finds that there is no material issue of fact that the defendants do not receive Federal financial assistance. Because the defendants do not receive such assistance, they are not subject to the Rehab Act and are entitled to summary judgment as to Mr. Waddell's claims under the Act. 29 U.S.C. §794(a).

Mr. Waddell's Claims Under the Americans with Disabilities Act

In order to prevail under the ADA, Mr. Waddell must prove all three elements of his prima facie case by a

preponderance of the evidence. See Doe v DeKalb County School District, 145 F.3d1441, 1445 (11th Cir. 1998). First, he must show he has a disability. Second, he must demonstrate that he is qualified to work as a dental hygienist, with or without some reasonable accommodation by the defendants, despite his disability. Third, he must show that he has suffered an adverse employment action because of his disability. See Harris v. H & W Contracting Co., 102 F.3d 516, 519, 523-524 (11th Cir. 1996) (discussing the elements of a prima facie case under the ADA).

The court assumes without deciding that Mr. Waddell has a disability under the ADA.[7]
Also, there has been no dispute that Mr. Waddell has suffered an adverse employment action. Therefore, the remaining question is whether Mr. Waddell is qualified. Mr. Waddell has set forth claims under both the ADA and the Rehab Act. As the court has already dismissed his claims under the Rehab Act, the court will only address the issue of whether Mr. Waddell is qualified under the ADA.

A "qualified individual with a disability" is defined as "an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires."

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[7] The Eleventh Circuit held in Doe v. DeKalb County School District that a "person infected with HIV is 'disabled' for purposes of the ADA, even if he has not developed AIDS" and cites the Supreme Court's decision in Bragdon v. Abbott, 524 U.S. 624, 118 S.Ct. 2196 (1998), as authority. 145 F.3d 1441, 1445 n. 5 (11th Cir. 1998). The court notes that the better approach is to determine a plaintiff's disability on a case-by-case basis. See Sutton v. United Air Lines, Inc., 527 U.S. 471, 119 S.Ct. 2139, 2147 (1999) (holding that whether a person has a disability within the meaning of the ADA is an individualized inquiry); 42 U.S.C. §12102(2).

42 U.S.C. §12111(8). However, a person who poses a significant risk of communicating an infectious disease to others will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk. School Board of Nassau County, Florida v. Arline, 480 U.S. 273, 287 n. 16, 107 S.Ct. 1123 (1987).

To determine whether a risk is significant, a district court must review four factors and examine how they interrelate with each other. The four factors are: (1) nature of the risk (how the disease is transmitted); (2) the duration of the risk (how long is the carrier infected) ; (3) the severity of the risk (what is the potential harm to third parties) ; and (4) the probability that the disease will be transmitted and will cause varying degrees of harm. Arline, 480 U.S. at 288, 107 S.Ct. at 1131. "The existence or non-existence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence." Bragdon, 524 U.S. at 649, 118 S.Ct. at 2210. In reviewing these factors, a district court "normally should defer to the reasonable medical judgment of public health officials." Arline, 480 U.S. at 288, 107 S.Ct. at 1131. The reasonable medical judgment of public health officials is only relevant if it assesses the level of risk. Bragdon, 524 U.S. at 652, 118 S.Ct. at 2211.

The evidence presented to the court to assess the significance of the risk that Mr. Waddell could infect a patient are the CDC's Recommendation for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures ("CDC I"); an update of the CDC's publication entitled Recommendations for Prevention of HIV Transmission in Health-Care Settings ("CDC II"); State of

Georgia Guidelines for the Management of the Immunodeficiency Virus (HIV) / Hepatitis B (HBV) Infected Health Care Workers; and several affidavits and expert reports/opinions of health care professionals presented by both the plaintiff and the defendants.

The court finds that the first two reports from the CDC and the affidavits of the health care professionals presented by Mr. Waddell represent the views of objective health care officials, but that the Georgia Guidelines, which are based on the CDC reports, do not. The Georgia Guidelines simply presents the policy of the State and guidelines for precautionary measures, it does not include an assessment of the risk of transmission when a dental hygienist performs procedures on patients. Further, the defendants did not submit the opinion of their expert in the form of an affidavit or declaration. Rather, they merely submitted a copy of the expert's report. It was not sworn to or notarized. Therefore, the court will not consider either the defendants' expert's report or the Georgia Guidelines in determining if Mr. Waddell presents a significant risk.

The Four-Part Inquiry

The parties in this case do not disagree as to the first three inquiries: nature, duration, or severity of the risk. The parties dispute is as to the probability that the disease will be transmitted. However, as all four of these inquiries must be considered together to determine whether Mr. Waddell poses a significant risk to others, the court will briefly discuss each.

First, the nature of the risk is essentially an examination of how the disease is transmitted. HIV is transmitted via blood, mucous membrane, and various bodily fluids such as semen, cerebro-spinal, and others usually as a

result of unprotected sex, sharing needles, in uteri exposure, or any other activity during which infected blood, semen, etc. can enter the blood, mucous membrane, or certain fluids of another person. Update: Universal Precautions for Prevention of Transmission of HIV, HBV, and Other Bloodborne Pathogens in Health-Care Settings ("CDC II"), p. 378.

Second, the duration of the risk, or how long the carrier is affected, is for the life of the infected individual. There is no known cure for HIV or AIDS at this time or at the time of the termination of Mr. Waddell.

Third, the severity of the risk represents the potential harm to third parties. The potential harm in a case where a person becomes infected is eventual death.

Finally, the probability that the disease will be transmitted is disputed by the parties. Initially, there is a dispute as to whether Mr. Waddell performs exposure-prone procedures as a dental hygienist. Mr. Waddell contends that because his hands are not simultaneously present in the mouth of a patient at the same time as sharp instruments, the procedures he performs are not exposure-prone. Mr. Waddell, however, admits that he performs some procedures which entail the use of sharp instruments. The document the court refers to as CDC I states that the "performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the [health care worker], and - if such an injury occurs - the [health care worker's] blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes." CDC I, p. 4. The court finds that the procedures performed by Mr. Waddell are exposure-prone because there is a risk that Mr. Waddell could suffer a percutaneous injury and his blood could contact any open

wounds or exposed mucous membranes of the patient.

The evidence presented by the parties which assesses the risk of transmission is inconsistent. Mr. Waddell's experts contend that he does not perform exposure-prone procedures and, therefore, if he uses universal precautions, there is only a theoretical risk of transmission. Affidavits of David Reznik, Joseph Wilber, John Molinari, and Donald Marianos. This position is supported by the CDC reports which agree that if a healthcare worker does not perform exposure-prone procedures and follows universal precautions, there is almost no risk of transmission. However, the court has already held that the procedures performed by Mr. Waddell are exposure-prone based on the CDC's definition of that term.

Conversely, the CDC reports state that when a healthcare worker performs exposure-prone procedures, there is a risk of transmission. CDC I states that even though at the time of that report a precise assessment of risk of transmission from a healthcare worker to a patient during an invasive procedure was not yet available, the current data suggested that the likelihood of such a transmission was small. Further, CDC I does state that the probability of transmission from a patient to a healthcare worker is assessed at .3%.

The Eleventh Circuit has stated that a test for assessing the results of these four inquiries in a case like the one at bar. When transmitting a disease inevitably entails death, the evidence supports a finding of "significant risk" if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease. Onishea v. Hopper, 171 F.3d 1289, 1297 (11th Cir. 1999). The Eleventh Circuit in Onishea was careful to

point out that the standard set out is not an "any risk" standard. Id. at 1299. The asserted danger of transmission must be based in sound medical opinion and not be speculative or fanciful. Id. However, evidence of actual transmission in the relevant context is not necessarily before a court can find a person presents a significant risk. Id.

The court finds that based on the objective medical evidence before it, there is a chance that Mr. Waddell could cut or prick himself and bleed into an open wound of a patient, and reliable medical opinions state that this event can transmit the disease. For these reasons, the court finds that Mr. Waddell, as employed as a dental hygienist, presents a significant risk to the patients of the defendants. Because he presents a significant risk, Mr. Waddell is not otherwise qualified and not covered by the ADA. Therefore, the defendants are entitled to summary judgment as to Mr. Waddell's claims under the ADA.

Mr. Waddell's 42 U.S.C. §1981a Claim

Section 1981a does not create an independent cause of action. Galliher v. Rubin, 969 F.Supp. 1329 (S.D.Ga. 1997). Rather, Section 1981a "is wholly dependent . . . on other substantive Acts" like the ADA or the Rehab Act. West v. Boeing Co., 851 F.Supp. 395, 401 (D.Kan. 1994). Section 1981a merely expands the remedies available under substantive acts and should only be regarded as an extension of and amendment thereto. Id. Because Section 1981a is not intended to stand alone as an independent cause of action and given that, in this case, summary judgment with respect to Counts I and II of the plaintiff's complaint has been granted in the defendants' favor, there remains in the plaintiff's action no substantive act, as required in Section 1981a, which may form the basis for unlawful intentional discrimination.

Consequently, summary judgment on the plaintiff's claim for damages under Section 1981a is also granted.

Mr. Waddell's State Law Claims

The court, having granted summary judgment to the defendants on all of Mr. Waddell's federal claims, declines to exercise pendent jurisdiction over his remaining state law claims. Carnegie-Mellon Univ. v. Cohill, 484 U.S. 343, 349-350, 108 S.Ct. 614, 619 (1988)(holding that exercise of pendent jurisdiction is at the discretion of the district court).

CONCLUSION

For the foregoing reasons, the court hereby GRANTS the defendants' motion for summary judgment [Doc. No. 18-1] as to all of the plaintiff's federal claims and declines to exercise pendent jurisdiction over the plaintiff's state law claims; DENIES the plaintiff's motion for partial summary judgment [Doc. No. 19-1]; GRANTS the plaintiff's motion for leave to file in excess of page limits [Doc. No. 23-1]; GRANTS the plaintiff's motion to substitute the affidavit of Donald Marianos [Doc. No. 27-1], which MOOTS the plaintiff's similar motion to substitute [Doc. No. 24-1]; DENIES the defendants' motions to strike the plaintiff's experts' affidavits [Doc. No. 22-1] and to strike the supplemental affidavit of Donald Marianos [Doc. No. 32-1]; and DENIES the plaintiff's motion to strike the defendants' expert [Doc. No. 26-1].

SO ORDERED, this 11th day of August, 2000.

CHARLES A. PANNELL, JR.
United States District Judge

Supreme Court, U.S.
FILED
MAR 25 2002
OFFICE OF THE CLERK

No. 01-1423

In The

Supreme Court of the United States

SPENCER WADDELL,

Petitioner,

v.

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether this Court should grant certiorari where the Court of Appeals properly applied the teachings of *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), and *Bragdon v. Abbott*, 524 U.S. 624 (1998), in this specific factual context and held that an HIV-positive dental hygienist was a direct threat to his patients because the evidence confirmed that he would have exposed his unsuspecting patients to a significant risk of contracting a fatal disease on a daily basis.

2. Whether this Court should grant certiorari on petitioner's claim that the Court of Appeals erred in requiring petitioner to bear the burden of proving that he was not a direct threat to his patients when petitioner never presented or preserved that issue in the lower courts and the lower courts' decisions were not based on the placement of the burden of proof in any event.

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT PURSUANT TO RULE 29.6

The parties to this proceeding are Spencer Waddell, Petitioner, and Valley Forge Dental Associates, Inc., Respondent.

Monarch Dental Corporation is the parent company of Valley Forge Dental Associates, and is Valley Forge's successor-in-interest.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT PURSUANT TO RULE 29.6 ii

STATEMENT OF THE CASE 1

A. Petitioner's Employment 1

B. The Decisions Below 4

SUMMARY OF THE ARGUMENT 6

REASONS FOR DENYING THE WRIT 7

A. The Eleventh Circuit's Ruling Does Not Conflict with Controlling Decisions of this Court 7

B. There is No Disagreement Among the Courts of Appeals Concerning the Proper Application of the Four Factors from *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), in Cases Involving Health Care Workers Infected with an Invariably Fatal Disease 16

C. Certiorari on the Question of the Proper Allocation of the Burden of Proof Is Not Appropriate Because the Issue Is Being Raised for the First Time in the Petition for Certiorari 24

CONCLUSION 27

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997), *vacated*, 524 U.S. 624, *aff'd on remand*, 163 F.3d 87 (1st Cir. 1998) 10, 20, 23

Adickes v. S.H. Kress & Co., 398 U.S. 144 (1972) 26

Auer v. Robbins, 519 U.S. 452 (1997) 25

Bradley v. Univ. of Texas, 3 F.3d 922 (5th Cir. 1993) 18

Bragdon v. Abbott, 524 U.S. 624 (1998) ..... *passim*

Capital Cities Cable, Inc. v. Crisp, 467 U.S. 691 (1984) 26

Carlson v. Green, 446 U.S. 14 (1980) 26

Chalk v. United States District Court, 840 F.2d 701 (9th Cir. 1988) 20, 22

City of Springfield v. Kibbe, 480 U.S. 257 (1987) 25

Den Hartog v. Wasach Acad., 129 F.3d 1076 (10th Cir. 1997) 24

Doe v. Univ. of Maryland Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995) 18

Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991) 19

EEOC v. AIC Sec. Invest., 55 F.3d 1276 (7th Cir. 1995) 24

EEOC v. Amego, Inc., 110 F.3d 135 (1st Cir. 1997) 24

Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398 (6th Cir. 1998) 18

Glover v. United States, 531 U.S. 198 (2001) 25

TABLE OF AUTHORITIES – Continued

Page

Grupo Mexicano de Desarrollo, S.A. v. Alliance Bond Fund, Inc., 527 U.S. 308 (1999) 25

Hamlin v. Charter Township of Flint, 165 F.3d 426 (6th Cir. 1999) 20, 21, 22

LaChance v. Duffy's Drafthouse, Inc., 146 F.3d 832 (11th Cir. 1998) 24, 25

Montalvo v. Radcliffe, 167 F.3d 873 (4th Cir. 1999) 19, 20, 21

Onishea v. Hopper, 171 F.3d 1289 (11th Cir. 1999) (*en banc*), *cert. denied*, 528 U.S. 1114 (2000) 5, 12, 19, 20, 21

Rizzo v. Children's World Learning Ctrs., 84 F.3d 758 (5th Cir. 1996) 15, 20, 21

Sch. Bd. of Nassau County v. Arline, 480 U.S. 273 (1987) 4, 6, 16

Scoles v. Mercy Health Corp., 887 F. Supp. 765 (E.D. Pa. 1994) 19

Stafne v. Unicare Homes, 266 F.3d 771 (8th Cir. 2001) 24

Taylor v. Freeland & Kronz, 503 U.S. 638 (1992) 26

FEDERAL STATUTES

28 U.S.C. § 791 3

42 U.S.C. § 1981a 4

42 U.S.C. § 12101 3

42 U.S.C. § 12101(a) 7

42 U.S.C. § 12111(3) 7

42 U.S.C. § 12111(8) 7

42 U.S.C. § 12113(b) 7

STATEMENT OF THE CASE

A. Petitioner's Employment

This case arises from petitioner Spencer Waddell's separation from his employment at the dental practice of Dr. Eugene Witkin, after Dr. Witkin determined that petitioner's HIV-positive status rendered him a direct threat to the health and safety of the thousands of unsuspecting adult and child patients he treated. Petitioner worked as a dental hygienist for Dr. Witkin intermittently from 1993 until October 1997. Dr. Witkin is a private dentist who had a practice management agreement with respondent, Valley Forge Dental Associates, Inc. ("Valley Forge"), petitioner's direct employer.[1]

In 1996, petitioner began experiencing health problems. Already believing that he would test positive for the Human Immuno-deficiency Virus ("HIV") based on a letter he had received from the American Red Cross in 1986 after having donated blood, petitioner sought medical attention to assess the progression of his HIV disease. At that time, he confirmed that he was HIV positive, although he never told Dr. Witkin or anyone else at his practice about it. In September 1997, petitioner went to a different physician, again to assess the progression of his disease. Feeling compelled to inform petitioner's employer of petitioner's condition given the nature of his work, the physician called Dr. Witkin and told him of

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[1] Subsequent to Mr. Waddell's termination, Valley Forge Dental Associates was acquired by Monarch Dental Corporation, which exists today and is Valley Forge's successor-in-interest. Pet., App. at A2. For convenience, respondent is referred to herein as "Valley Forge."

petitioner's HIV positive status. Upon learning that petitioner was HIV positive, Dr. Witkin placed petitioner on a paid leave of absence for two weeks and began investigating how to deal with the situation. *See* Pet., App. at A3.

Dr. Witkin immediately sought guidance from public health authorities on both HIV and Acquired Immunodeficiency Syndrome ("AIDS"), and reviewed relevant literature from the Centers for Disease Control ("CDC"). *Id.* The CDC guidelines state that health care workers who perform "exposure prone procedures" pose a risk of transmitting the disease to patients despite the use of available precautions. *Id.*, App. at A24.

As a dental hygienist, it is undisputed that petitioner manipulated various sharp, pointed and bladed instruments with his hands within the mouths of his patients. Valley Forge presented uncontradicted evidence establishing that, given such a confined and poorly visible area, it is not uncommon for a hygienist to "stick" or cut himself or herself during the course of rendering treatment, nor is it uncommon for a dental hygienist to be bitten accidentally by a patient. *See* Pet., App. at A10-A13.[2] In fact, both Dr. Witkin and another hygienist, Jill Whelchel, testified that they have stuck or cut themselves while treating patients. *See id.* at A11. Moreover, two of the procedures performed by petitioner on nearly every

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[2] Even petitioner testified that he has cut himself while treating a patient, although fortunately for the patient, his hands were not in the patient's mouth at the time. Pet., App. at A11.

patient – "scaling" and "root planing" – pose a particularly high risk of injury to the dental hygienist and unavoidable bleeding to the patient.[3] *Id.* at A10.

Based on all of the information gathered by and presented to Dr. Witkin, including the CDC guidelines, his own personal experience working with hygienists and treating patients, and his knowledge of the essential functions performed by a dental hygienist in his practice, Dr. Witkin concluded that there was a distinct and realistic possibility that petitioner could infect one of his unsuspecting patients with HIV by sticking or cutting himself with a sharp instrument while performing invasive procedures in the patient's mouth. Having decided that permitting petitioner to continue treating patients in his practice presented a real and unacceptable risk of catastrophic proportion to his patients, Dr. Witkin met with petitioner and informed him that he could no longer treat patients. *Id.* at A3.

Because petitioner had been a good employee, Dr. Witkin offered to transfer petitioner to a non-clinical position. Petitioner declined that offer and subsequently brought this action, claiming that Valley Forge violated the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, the Rehabilitation Act, 28 U.S.C. § 791 *et seq.*, and

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[3] Scaling requires the dental hygienist to manipulate a sharp dental instrument along tooth surfaces and below the gumline to scrape away and remove plaque, calculus, tartar and other material or stains from the surfaces. Root planing involves the smoothing of the patient's root surfaces below the gumline, again with a sharp instrument. Pet., App. at A10.

several state laws by discriminating against him on the basis of a disability, HIV-positive status.

B. The Decisions Below

After discovery, the parties filed cross-motions for summary judgment. The United States District Court for the Northern District of Georgia granted summary judgment to Valley Forge, concluding that petitioner was not an "otherwise qualified employee" under the ADA.[4] The District Court reviewed the four factors set forth in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), to determine whether there was a significant risk, and therefore, a direct threat of harm: (1) the nature of the risk (how the disease is transmitted); (2) the duration of the risk (how long the carrier is infected); (3) the severity of the risk (what the potential harm is to third parties); and (4) the probability that the disease will be transmitted and will cause varying degrees of harm. The District Court concluded that petitioner posed a significant risk because the undisputed evidence confirmed that there was a chance that petitioner could cut himself while treating a patient and consequently bleed into a patient's open wound or mucous membrane, and HIV is a communicable disease transmittable in that fashion that

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[4] The District Court also dismissed petitioner's Rehabilitation Act claim because Valley Forge does not receive federal financial assistance, Pet., App. at A20, and his claim under 42 U.S.C. § 1981a because it does not provide an independent cause of action. Finally, the District Court declined to exercise supplemental jurisdiction over petitioner's state law claims.

inevitably causes death to the infected individual. Pet., App. at A26.

The Court of Appeals for the Eleventh Circuit affirmed, applying the *Arline* factors to the particular factual setting before it. Following its *en banc* decision in *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999) (*en banc*), *cert. denied*, 528 U.S. 1114 (2000), the Eleventh Circuit explained that when transmitting a disease inevitably entails death, the probability of harm – *Arline*'s fourth factor – will be sufficient to establish a significant risk if the evidence shows both "(1) that a certain event can occur; and (2) that according to reliable medical opinion, the event can transmit the disease." *Id.* at 1299. It agreed with the District Court's analysis of the objective evidence indicating that petitioner, because he is infected with HIV, which is both contagious and fatal, was a direct threat to the patients he treated. The court found that "the uncontroverted evidence establishes that a dental worker sometimes does stick or cut herself during treatment," and "an inadvertent bite or some other accident during cleaning" could lead to exposure of petitioner's blood in a patient's cut or abrasion. Pet., App. at A11, A13. Moreover, the court relied on the fact that petitioner's medical experts did not dispute that transmission could occur from petitioner to one of his patients, with fatal consequences. *Id.* at A12. Looking at all of the "best available objective evidence," the court ruled in Valley Forge's favor. *Id.* at A13.

SUMMARY OF THE ARGUMENT

Petitioner has not presented any compelling reason for this Court to exercise jurisdiction over his appeal of the dismissal of his claim. As the District Court and the Eleventh Circuit properly found, the undisputed facts of this case demonstrate that there was a significant risk that petitioner would infect his patients with a fatal disease when he engaged in exposure-prone procedures that were an essential function of his position as a dental hygienist. Both lower courts reached this conclusion after carefully considering the "objective evidence" that was available to the decisionmaker as this Court instructed in *Bragdon v. Abbott*, 524 U.S. 624, 650 (1998), and the four factors for assessing the risk of exposure first articulated in this Court's decision in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987).

Moreover, the District Court's and Eleventh Circuit's rulings in this case are consistent with decisions from every circuit court that has considered a case involving a health care worker infected with an inevitably fatal disease who engages in exposure-prone procedures in their profession. Finally, certiorari review of the question of which party bears the burden of proof on the prima facie case issue of direct threat under the ADA is inappropriate because petitioner failed to raise that issue in the District Court or the Court of Appeals.

Simply put, petitioner has not presented any compelling reason for this Court to exercise discretionary jurisdiction over his appeal of the dismissal of his claim. Accordingly, his petition for certiorari should be denied.

REASONS FOR DENYING THE WRIT

A. The Eleventh Circuit's Ruling Does Not Conflict with Controlling Decisions of this Court.

In a transparent attempt to grab this Court's attention, petitioner argues that the Eleventh Circuit's ruling is in "striking conflict" with this Court's decision in *Bragdon v. Abbott*, 524 U.S. 624. Pet. at 14. He also maintains that the Eleventh Circuit applied a standard for assessing what constitutes a "significant risk" of harm that is a "result-altering departure" from the standard for determining direct threat developed by this Court. Pet. at 15. However, petitioner mischaracterizes this Court's decision in *Bragdon* and distorts the Eleventh Circuit's holding in the hope of creating the false appearance of an issue worthy of this Court's consideration where none exists.

The ADA prohibits employers from discriminating against qualified individuals with a disability. 42 U.S.C. § 12101(a); *Bragdon*, 524 U.S. at 628. A qualified individual with a disability is one who can perform the essential functions of the job at issue, with or without reasonable accommodation. 42 U.S.C. § 12111(8). An individual is not "otherwise qualified" and thus cannot establish a prima facie case of discrimination under the ADA if he poses a direct threat to others. 42 U.S.C. § 12113(b). The ADA defines a "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." *Id.* § 12111(3); *see also Bragdon*, 524 U.S. at 648-49.

In *Bragdon*, the plaintiff, Sydney Abbott, an HIV-positive patient, challenged her dentist's refusal to treat her in his office rather than in a hospital setting based on the defendant dentist's belief that she posed a direct threat of exposure to the HIV virus. The district court granted summary judgment to the plaintiff under the ADA and the First Circuit affirmed, finding that Abbott demonstrated as a matter of law that there was not a significant risk that she would infect her dentist during the course of treatment. This Court granted certiorari with respect to the direct threat provision of the ADA on a narrow issue:

> When deciding under Title III of the ADA whether a private health care provider must perform invasive procedures on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?

524 U.S. at 648.

After noting that the requirement of a "significant risk" was adopted in *Arline*, this Court held that "the existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence." *Id.* at 649. Thus, the challenged action must be evaluated "based on the objective, scientific information available" at the time the decision is made, and the dentist's unfounded belief that a significant risk existed

"even if maintained in good faith," would not relieve an individual or employer from liability.[5] *Id.*

Petitioner's assertions to the contrary, there is nothing about the Eleventh Circuit's analysis that conflicts with *Bragdon*. Simply put, this Court's decision in *Bragdon* did not address the issue presented by the facts of this case. Indeed, this Court did not discuss or apply the four factors articulated in *Arline*, much less consider the appropriate weight to be given to each factor where the severity of the harm, if inflicted upon an unsuspecting patient by a health care worker, is inevitable death. Rather, the Court considered the narrow question of whether, in assessing if a risk is "significant," courts must afford special deference to the health care provider's professional judgment. The Court's straightforward answer to that question, as described above, was "no." Even petitioner admits in his brief that "this Court did not address directly the level of weight to be afforded the 'probability' factor of the ADA standard in *Bragdon*. . . . " Pet. at 15. Thus, petitioner's argument that the Eleventh Circuit's decision is in "striking conflict" with *Bragdon* is defeated by his own admission.

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[5] This Court also addressed the question assumed in the question presented, *i.e.*, whether petitioner's refusal to treat his patient was reasonable in light of the medical evidence. After reviewing the evidence presented in support of Abbott's claim and questioning certain aspects of it, this Court remanded the matter to the First Circuit to determine, in the first instance, if the dentist presented sufficient "objective evidence" to defeat Abbott's motion for summary judgment on the direct threat issue. *Id.* at 650-55.

Apart from the fact that *Bragdon* did not address the issue presented here, there is another, perhaps more significant, reason why the result in this case is consistent with *Bragdon*. Indeed, petitioner overlooks the critical factual distinction that *Bragdon* involved a doctor explicitly refusing to treat a disabled person in his office rather than a hospital out of fear for his own health. In sharp contrast, this case involves an HIV positive health care worker performing exposure-prone procedures on thousands of unwitting patients. Unlike the dentist defendant in *Bragdon*, Dr. Witkin's concern was not for his own health, but for the safety of his unsuspecting adult and child patients who would be treated by petitioner and potentially exposed to a fatal infectious disease. As the First Circuit aptly observed in *Bragdon* itself, this factual distinction is "meaningful." *Abbott v. Bragdon*, 107 F.3d 934, 946, 947 (1st Cir. 1997), *vacated on other grounds*, 524 U.S. 624, *aff'd on remand*, 163 F.3d 87 (1st Cir. 1998).[6] And,

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[6] Further recognizing that the concerns raised by an HIV-positive health care worker treating an unsuspecting patient are appreciably different than those present in the converse situation, the First Circuit rejected the defendant's reliance on a CDC report indicating that a Florida dentist transmitted HIV to his patient. *Bragdon*, 107 F.3d at 947. The court found that the report was not probative of the risk posed to the defendant in treating the plaintiff, explaining:

> Dentists have the advantage of equipping and staffing their offices and dictating the precautionary procedures that will be utilized during patient encounters. In contrast, patients have no way of assuring that any particular risk-reduction measures, much less universal precautions recommended by the CDC, are introduced. Given that dentists are in a superior position to patients in terms of protecting

unlike the dentist in *Bragdon* who presented no objective medical evidence to support his self-serving position that treating the plaintiff in the hospital would reduce the possibility of transmission to him, Dr. Witkin's decision was based on objective medical evidence and the opinion of public health authorities establishing that petitioner's performance of exposure-prone procedures presented a real risk of transmission to his patients.

Petitioner nevertheless blatantly mischaracterizes the Eleventh Circuit's holding as "a result-altering departure from the standard for determining direct threat developed by this Court" because the court supposedly adopted a standard that "*any* risk of death greater than absolute zero constitutes a direct threat." Pet. at 14-15 (emphasis added). He contends that the Eleventh Circuit's analysis effectively eliminates consideration of the fourth factor in *Arline* – the probability of harm – when the harm, if inflicted, is inevitable death. He boldly characterizes the lower court's decision as holding that "any theoretically supportable theory of HIV transmission will support a direct threat finding . . . no matter how miniscule the chance that transmission will actually occur." Pet. at 12. Petitioner's characterization of the Eleventh Circuit's holding and rationale is nonsensical.

As argued above, in evaluating the fourth *Arline* factor and ultimately concluding that petitioner posed a

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> against infection, a single report of dentist-to-patient infection cannot reasonably be taken to suggest a direct threat to dentists from their patients' infections.

Id.

"significant risk" to his patients, the Eleventh Circuit applied the standard set forth in its previous *en banc* decision in *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999) (*en banc*), *cert. denied*, 528 U.S. 1114 (2000). There, the court elaborated on the four-part *Arline* analysis in a case involving the possible transmission of HIV in prisons. The court reasoned that "the significance of a risk is a product of the odds that transmission will occur and the severity of the consequences." *Id.* at 1297. Indeed, "it is the potential gravity of the harm that imbues certain odds of an event with significance." *Id.* The court held that "when the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low: death itself makes the risk significant." *Id.*

Importantly, and in direct conflict with petitioner's unfounded assertions about the nature of the Eleventh Circuit's holding in the instant case, *see* Pet. at 14, the *Onishea* court explicitly rejected an "any risk" standard that would completely eliminate an analysis of the probability that HIV exposure could occur. The court specifically stated: "This is not an 'any risk' standard: the asserted danger of transfer must be rooted in sound medical opinion and not be speculative or fanciful." *Onishea*, 171 F.3d at 1299. The court pointed out that "saying a risk of an event is small does not mean it will not happen." *Id.* The court determined that even a small risk would be significant to a person infected with a fatal disease, noting that "each time the event occurs, it is real people – not cold ciphers – that suffer the consequences." *Id.*

Petitioner conveniently overlooks those portions of *Onishea* and the lower court's decision in this case that confirm that the Eleventh Circuit's standard is not an "any risk" standard. The Eleventh Circuit's decision in this case did not, as petitioner suggests, remove the fourth factor of *Arline* from the analysis simply because the harm at issue is inevitable death and did not hold that any risk of death greater than "absolute zero" constitutes a direct threat. Rather, the Eleventh Circuit's decision simply recognized, as does petitioner himself, that the *Arline* factors require "[p]roper balancing," Pet. at 14, depending on the factual circumstances, and the "likelihood sufficient to establish a direct threat that a harm will occur will become smaller in inverse proportion to the seriousness of the harm that is risked." *Id.* Again, by his own admission, petitioner recognizes the validity of the Eleventh Circuit's approach in this case.

At bottom, petitioner's entire argument centers around his assertion that the Eleventh Circuit's decision is a radical departure from this Court's precedent. In reality, however, the lower court's decision is nothing more than a straightforward application of the four factors articulated in *Arline* to the facts of the particular case before it. Because there was no real dispute between the parties with respect to the first three *Arline* factors – nature of the risk (how the disease is contracted), duration of the risk (petitioner is infected for the remainder of his life), and severity of the risk (inevitable death of the patient) – the Eleventh Circuit focused on the last factor, which is the probability of transmission of HIV between petitioner and a patient. Pet., App. at A9. In assessing the probability of transmission, the court recognized that the

significance of each factor must be assessed, and may vary, in light of the unique facts of each case, explaining that "[w]hen the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low. . . ." Pet., App. at A7. Given *Bragdon*'s admonition to assess the risk of infection based on " 'objective scientific information,' " *id.* (quoting *Bragdon*, 524 U.S. at 649) and other "available objective evidence," *Bragdon*, 524 U.S. at 649, the Eleventh Circuit emphasized that the possibility of transmission must not be "speculative or fanciful." Rather, the evidence that must be "rooted in sound medical judgment," Pet., App. at A7, which is hardly a departure from or inconsistent with *Arline* and *Bragdon*.

After reviewing all of the objective evidence before it, including the CDC guidelines, petitioner's medical experts' testimony that a hygienist's fingers and sharp instruments are simultaneously in the patient's mouth during at least some of the treatment process, testimony confirming that patients' mouths frequently bleed during routine treatment, and proof that cuts and abrasions to the hygienist's fingers have occurred in the past, the court found that the risk of transmission was not "speculative." Rather, the risk of transmission was "significant" because the proofs confirmed that exposure could occur and that catastrophic consequences would result if even one patient were infected. Thus, consistent with *Bragdon*, the lower court examined the "medical or other objective evidence," 524 U.S. at 649, and consistent with *Arline*, conducted an "individualized inquiry." 480 U.S. at 287 (stating that "such an inquiry is essential if [the Act]

is to achieve its goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns as avoiding exposing others to significant health and safety risks").

Ignoring the fact-specific and limited nature of the Eleventh Circuit's holding and the uniqueness of the situation that his case presented, petitioner envisions a "host of imaginable disasters," Pet. at 16, that will flow from the court's decision that effectively will prevent any disabled person from holding a job. For example, petitioner claims that the lower court's ruling will prevent an HIV-positive applicant from attaining an office position, an HIV-positive teacher from remaining in the classroom, a firefighter with hepatitis C from fighting fires, and a wheelchair bound individual from managing a day-care center.

Simply put, petitioner is comparing apples to oranges; consistent with his position throughout this litigation, he simply refuses to confront the fact that the threat that he poses to his innocent patients is radically different – and more serious – than the hypotheticals he proposes. Indeed, none of these scenarios involves the same level of risk of certain death that petitioner posed to the thousands of unsuspecting patients – adults and children[7] – on whom he performed exposure-prone

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[7] As the Fifth Circuit noted in *Rizzo v. Children's World Learning Centers, Inc.*, 84 F.3d 758, 764 (5th Cir. 1996), "[t]hat any potential harm will befall children, the most vulnerable members of our society, will greatly impact the consideration of [t]he nature and severity of the potential harm." *Id.* (internal quotation marks omitted).

procedures on a daily basis. Unlike the case before the Court, in none of petitioner's fantasy scenarios is there CDC guidance identifying a "recognized risk" of exposure. It defies common sense to suggest that an office worker or teacher with HIV engages in everyday tasks that pose the same degree of risk of infection and death as an HIV-positive dental hygienist working with sharp instruments in invariably bleeding mouths of thousands of patients annually.

Petitioner also fails to recognize that his firefighter and day-care worker analogies are flawed because neither presents a situation where the harm that follows, should a particular event occur, is *certain* death to a third party. Again, petitioner's alarmist arguments are a transparent attempt to convince the Court that the holding below will lead to absurd results, when it plainly will not.

B. There is No Disagreement Among the Courts of Appeals Concerning the Proper Application of the Four Factors from *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), in Cases Involving Health Care Workers Infected with an Inevitably Fatal Disease.

In addition to suggesting that the Eleventh Circuit's ruling conflicts with Supreme Court precedent, petitioner argues that there is a larger disagreement among the Courts of Appeals concerning the application of *Arline*'s four factor test when the harm at issue has "potentially fatal consequences." *See* Pet. at 18. Once again, petitioner's attempt to create an issue worthy of this Court's consideration is unsuccessful.

Petitioner's attempt to manufacture a circuit split misses the mark because his argument begins from a faulty premise – namely, that this case involves a risk of "potentially fatal consequences" similar to the cases on which he relies. What he apparently fails to appreciate is that this case is not about the *possibility* that a person could die from exposure to petitioner's fatal disease; rather, it is about *certain* death to a third party in the event of exposure and how that stark reality necessarily impacts the overall fact-specific significant risk analysis contemplated in *Arline*.

There is no "larger disagreement" among the Courts of Appeals concerning the application of the *Arline* test in a situation such as that presented here, where the potential risk to third parties, if a certain event occurs, is inevitable death. While petitioner cites several irrelevant cases in the hopes of creating the illusion of a circuit split where there is none, petitioner conveniently overlooks those cases that have addressed the direct threat issue in factually analogous circumstances. Indeed, petitioner failed to mention the fact that *every* circuit court that has considered a case involving an HIV-positive health care worker who performs exposure-prone procedures has reached the same conclusion as the Eleventh Circuit.

In concluding in each case that the plaintiff health care worker posed a significant risk to patients, the Courts of Appeals for the Fourth, Fifth and Sixth Circuits evaluated the severity of the harm and evidence concerning the likelihood of transmission and determined that the inevitably fatal nature of the HIV virus rendered the odds of transmission significant under *Arline*. The courts recognized that the fact-intensive nature of the analysis

under *Arline* and the severity of the harm at issue necessarily impacted the overall inquiry. *See Estate of Mauro v. Borgess Med. Ctr.*, 137 F.3d 398, 407 (6th Cir. 1998) (concluding that surgical technician was a direct threat to patients, where employer considered same CDC guidelines as Valley Forge and determined that plaintiff engaged in exposure-prone procedures; court relied on description of job responsibilities, the fact that plaintiff sustained a needle laceration in the past and the "uncontradicted fact that a wound causing an HIV-infected surgical technician to bleed while in the body cavity could have catastrophic results"); *Doe v. Univ. of Maryland Med. Sys. Corp.*, 50 F.3d 1261, 1266 (4th Cir. 1995) (finding that HIV-positive neurosurgery resident posed significant risk to patients because he engaged in exposure-prone procedures; court rejected plaintiff's argument that the risk that he would transmit HIV to one of his patients was so infinitesimal that it could not be considered a significant risk, regardless of the degree of harm involved, stating that "some measure of risk will always exist because of the type of activities in which [the physician] is engaged"); *Bradley v. Univ. of Texas*, 3 F.3d 922, 924 (5th Cir. 1993) (finding that surgical technician was not "otherwise qualified" where evidence showed that plaintiff frequently handled sharp instruments near open wounds and body cavity, his hands were in body cavity and he admitted that accidents occurred; court noted that "while the risk [of transmission] is small, it is not so low as to nullify the catastrophic consequences of an accident").[8]

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[8] Other cases, not arising in the health care context, nevertheless recognize the import of the fact that HIV exposure

Moreover, at least two district courts have reached the same conclusion in factually analogous circumstances. *See Scoles v. Mercy Health Corp.*, 887 F. Supp. 765, 770 (E.D. Pa. 1994) (granting summary judgment against HIV-positive orthopedic surgeon: "Since the risk will endure as long as [the plaintiff] performs surgery and the harm is a fatal disease, [p]laintiff does not convince the court that he is not a 'direct threat' and entitled to judgment as a matter of law."); *Doe v. Washington Univ.*, 780 F. Supp. 628, 633-34 (E.D. Mo. 1991) (granting summary judgment against HIV-positive dental student: "To permit even an occasional death to occur because of a failure to scrupulously guard the safety of patients would appear to be morally unacceptable and contrary to the fiduciary responsibilities of the medical profession. While doctors emphasize the danger, statistically, is slight, the victim of infection by this rare but fatal infection can hardly be consoled by the odds.").

Rather than focusing on these factually analogous cases, petitioner attempts to distract the Court by continuing to state incorrectly that the Eleventh Circuit adopted an "any risk" standard that would permit any possibility of transmission, regardless of how remote or speculative, to constitute a "significant risk." Pet. at 18.

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results in inevitable death. *See, e.g., Onishea*, 171 F.3d at 1297 (explaining that "the potential gravity of the harm . . . imbues certain odds of an event with significance;" "we are far more likely to consider walking a tightrope to pose a significant risk if the rope is fifty feet high than if it is one foot off the ground."); *Montalvo v. Radcliffe*, 167 F.3d 873, 878 (4th Cir. 1999) (noting that "the gravity of one factor might well compensate for the relative slightness of another").

And, as set forth above, he ignores the factually analogous cases and cites a number of inapposite cases in an attempt to create a circuit split where there is none. Specifically, petitioner claims that decisions from the Eleventh and Fourth Circuits are inconsistent with decisions in the First, Fifth, Sixth and Ninth Circuits concerning the weight to be afforded to the last *Arline* factor – the probability of harm. He characterizes the Eleventh and Fourth Circuits as having ruled that, where the risk at issue is exposure to a deadly disease, "any risk of death" is significant, regardless of how remote or speculative the possibility is that it will occur, while the First, Fifth, Sixth and Ninth Circuits have declined to find that the risk of death is significant if the probability that it will occur is small. Pet. at 18-22 (citing *Hamlin v. Charter Township of Flint*, 165 F.3d 426 (6th Cir. 1999); *Abbott v. Bragdon*, 163 F.3d 87 (1st Cir. 1998); *Rizzo v. Children's World Learning Ctrs.*, 84 F.3d 758 (5th Cir. 1996); *Chalk v. United States District Court*, 840 F.2d 701 (9th Cir. 1988)). His arguments miss the mark.

First, as previously stated, the Eleventh Circuit's opinion in *Onishea* explicitly rejected the "any risk" standard that petitioner urges it adopted. The Eleventh Circuit stated that the danger of transmission must be "rooted in sound medical opinion and not be speculative or fanciful."[9] *Onishea*, 171 F.3d at 1299.

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[9] Similarly, petitioner improperly characterized the Fourth Circuit's decision in *Montalvo* as having adopted an "any risk" of death standard. In *Montalvo*, the court considered the probability of a child transmitting the HIV virus in a karate class in which the participants often sustained bloody injuries and engaged in body contact. Relying on evidence confirming those

Second, while it is true that certain of the cases petitioner cites reached different results in addressing the direct threat issue, each is factually distinguishable from the present case. In any event, the analysis in all of the cases is the same; each court applied the four factors in *Arline* and assessed each factor based on the circumstances presented. Thus, rather than demonstrating that a circuit split exists, the divergent results actually underscore the reality that the four-factor analysis from *Arline* mandates an "individualized inquiry" into the facts of each case. 480 U.S. at 287.

For example, petitioner conveniently fails to point out that *Rizzo* and *Hamlin* are factually distinguishable because they did not involve situations where the nature and severity of harm, if it occurred, was certain death to an innocent third party. In *Rizzo*, the Fifth Circuit addressed a claim by a hearing impaired employee who was prohibited from driving a school van with children because she might not be able to hear a child choking in the back of the van.[10] 84 F.3d at 760-61. *Hamlin* involved

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facts, the court found that it was sufficient to create a significant risk under *Arline*. 167 F.3d at 878. Similar to the Eleventh Circuit's analysis in *Onishea*, the *Montalvo* court noted that "when the disease at risk of transmission is, like AIDS, severe and inevitably fatal, even a low probability of transmission could still create a significant risk." *Id.*

[10] Petitioner also mischaracterizes the holding in *Rizzo*. In *Rizzo*, the court did not, as petitioner suggests, remand the case to the district court to consider whether the harm in question was "*significantly* likely to occur." Pet. at 21. Rather, the court simply held that there was a genuine issue of material fact as to whether a hearing impaired individual posed a direct threat to school children by driving a school van. *Rizzo*, 84 F.3d at 764.

an assistant fire chief who was terminated because of a medical restriction on his ability to engage in front-line firefighting, despite the fact that participation in active firefighting was not an essential function of the position of assistant fire chief. 165 F.3d at 432. While both cases presented a remote risk that an event could occur that could cause injury or death to a third party, death was not necessarily an inevitable consequence of the risk that each plaintiff's disability posed. Moreover, and perhaps more importantly, neither case involved an HIV-positive health care worker performing exposure-prone procedures on unsuspecting third parties, including children.

Petitioner also inexplicably relies on the Ninth Circuit's decision in *Chalk*, where a teacher was relieved of his classroom duties because he suffered from AIDS. The district court denied the teacher's motion for a preliminary injunction based on the opinion of one doctor who opined that AIDS could be contracted through casual contact. The Ninth Circuit reversed that determination because the "overwhelming consensus" of medical opinion confirmed that AIDS could only be transmitted in limited ways and not through casual contact. 840 F.2d at 707-08. While petitioner seizes upon the Ninth Circuit's statement that "it was error to require that every theoretical possibility for harm be disproved," *id.* at 709, the court made that statement in the context of rejecting the district court's reliance on the possibility of casual transmission of the disease where the scientific evidence showed otherwise. *See id.*

Here, the risk of transmission in connection with petitioner's performance of his job is "recognized" by the CDC. In any event, the activities that occur in a classroom

setting are appreciably different than the exposure-prone procedures that petitioner performed on a daily basis.

And, despite petitioner's continued reference to *Bragdon*, that case also is inapposite because, as previously explained, it involved a dentist refusing treatment to an HIV positive patient – the converse of the situation presented here. Notably, in arguing that his patient posed a direct threat to his safety, the dentist in *Bragdon* relied on the cases cited above addressing whether an HIV-positive health care worker posed a direct threat to patients. The original panel of the First Circuit rejected this attempted analogy, correctly recognizing that "the federal cases involving transmission of HIV from health-care workers to patients are inapposite." 107 F.3d at 948. This part of the First Circuit's analysis was not disturbed by this Court or the First Circuit on remand. Thus, petitioner's citation to *Bragdon* in the hopes of demonstrating that the First Circuit would have reached a different result in this case is unavailing.

Based on the foregoing, petitioner's unfounded concern that "the same plaintiff with the same facts can expect very different results depending on the circuit" is easily put to rest. Pet. at 22. Rather than conflicting with the relevant case law on this issue, the Eleventh Circuit's ruling is consistent with the cases on point. The purported conflict raised by petitioner does not exist, and review by this Court is unnecessary.

C. Certiorari on the Question of the Proper Allocation of the Burden of Proof Is Not Appropriate Because the Issue Is Being Raised for the First Time in the Petition for Certiorari.

Finally, petitioner urges this Court to grant certiorari on the question of which party should bear the burden of proof on the existence of a direct threat under the ADA. Pet. at 22. Petitioner claims that there is a split among the circuits concerning which party must establish the presence or absence of a direct threat. Pet. at 23. However, certiorari on this question is not appropriate because petitioner has waived that argument by not raising any challenge relating to the burden of proof in the proceedings below.[11]

Conspicuously absent from petitioner's short discussion of this issue in his petition is any citation to the record below where he presented an argument concerning the proper allocation of the burden of proof on the issue of direct threat under the ADA. The reason for the lack of citation to the record is because petitioner never made any such argument, or objected to the court's

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[11] Contrary to petitioner's assertion, review also is inappropriate because there is no significant divergence of opinion on this issue. Indeed, many of the cases petitioner cites placed the burden on one party without specifically addressing the issue. *E.g., LaChance v. Duffy's Drafthouse, Inc.*, 146 F.3d 832, 836 (11th Cir. 1998); *Den Hartog v. Wasach Acad.*, 129 F.3d 1076, 1089 (10th Cir. 1997); *EEOC v. AIC Sec. Invest.*, 55 F.3d 1276, 1284 (7th Cir. 1995). One court limited its holding to the facts, *e.g., EEOC v. Amego, Inc.*, 110 F.3d 135, 144 (1st Cir. 1997), and one court declined to reach the issue. *E.g., Stafne v. Unicare Homes*, 266 F.3d 771, 775 (8th Cir. 2001).

placement of the burden, before the District Court or the Court of Appeals. Moreover, the lower courts never considered the issue because it was not briefed or argued. Notably, the Equal Employment Opportunity Commission ("EEOC"), in its amicus brief before the Eleventh Circuit, conceded that petitioner had the burden of proving that he did not constitute a direct threat to his patients. *See* Resp. App. at 2 (EEOC Br. at 20 ("This Court has ruled that the plaintiff has the burden of proving he does not pose a direct threat. *LaChance v. Duffy's Drafthouse, Inc.*, 146 F.3d 832, 836 (11th Cir. 1998).")). The placement of the burden of proof simply was not an issue until this point in the proceedings.

In his briefs before the Eleventh Circuit and at oral argument, petitioner did not contend that the District Court misapplied the burden of proof or that the Eleventh Circuit's previous decision in *LaChance* was incorrect. Because petitioner failed to preserve his claim concerning the proper allocation of the burden of proof before the District Court or the Court of Appeals and because neither court has considered the question, this Court should deny petitioner's eleventh-hour attempt to raise the issue. *See Glover v. United States*, 531 U.S. 198, 205 (2001) ("In the ordinary course we do not decide questions neither raised nor resolved below"); *Grupo Mexicano de Desarrollo, S.A. v. Alliance Bond Fund, Inc.*, 527 U.S. 308, 318 n.3 (1999) (dismissing writ as improvidently granted and declining to reach argument "neither raised nor considered below"); *Auer v. Robbins*, 519 U.S. 452, 464 (1997) (stating that it would not consider argument that was inadequately preserved in prior proceedings); *City of Springfield v. Kibbe*, 480 U.S. 257, 259-60 (1987) (declining

to decide issue where petitioner did not properly preserve argument in District Court or make argument in Court of Appeals, Court of Appeals did not address the issue and respondent objected to Supreme Court's consideration of issue in opposition brief); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147 n.2 (1970) (declining to consider argument that Court should overrule prior precedent and permit claim where petitioner never raised issue in the Court of Appeals).

Moreover, in the present case, there are no "unusual circumstances" that would warrant disregarding this general rule, which "maintain[s] the integrity of the process of certiorari." *Taylor v. Freeland & Kronz*, 503 U.S. 638, 646 (1992); *cf. Capital Cities Cable, Inc. v. Crisp*, 467 U.S. 691, 697-98 (1984) (Court ordered parties to brief issue raised in amicus brief and considered issue on the merits where "the conflict between Oklahoma and federal law was plainly raised in petitioner's complaint, it was acknowledged by both the District Court and the Court of Appeals, the District Court made findings on all factual issues necessary to resolve this question, and the parties briefed and argued the question"); *Carlson v. Green*, 446 U.S. 14, 17 n.2 (1980) (holding that "interests of judicial administration" allowed Court to consider question presented for the first time in petition for certiorari where respondent did not object to the Court's consideration of it, the issue was squarely presented and fully briefed, it was "an important, recurring issue," and it was properly raised in another petition for certiorari that was held pending disposition of case).

Finally, putting aside the fact that petitioner failed to preserve the issue for appellate review, there is an

additional reason why this Court should not grant certiorari on petitioner's contention that the Eleventh Circuit improperly placed the burden of proof on petitioner. Simply put, the lower courts' decisions did not turn upon which party had the burden of proof on the direct threat issue. Indeed, both the District Court and the Court of Appeals considered all of the evidence presented by both parties and evaluated petitioner's claim based upon its totality. Accordingly, this case raises no significant issue concerning who should bear the burden of proof, and review should be denied.

CONCLUSION

For all of the foregoing reasons, Respondent respectfully requests that this Honorable Court deny the Petition.

Respectfully submitted,

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April 25, 2002

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 00-14896-A

SPENCER WADDELL,

Plaintiff-Appellant,

v.

VALLEY FORGE DENTAL ASSOCIATES, INC., and JOHN DOE, as successor-in-interest of VALLEY FORGE DENTAL ASSOCIATES, INC.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of Georgia

BRIEF OF THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT SPENCER WADDELL

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* * *

he is qualified, a person must show that he has the requisite skill, licenses, employment experience and educational background, and that he can perform the job with or without a reasonable accommodation. 29 C.F.R. § 1630.2(m).

A disabled individual is not otherwise qualified, however, if he presents a direct threat to his own or others' safety. To establish that a disabled person is a "direct threat," it must be shown that the employee's disability presents "a significant risk of substantial harm- . . . that cannot be eliminated or reduced by reasonable accommodation." 29 C.F.R. § 1630.2(r); *See also Bragdon*, 524 U.S. at 648(ADA); *School Bd. of Nassau County, Fla. v. Arline*, 480 U.S. 273, 287 n.16 (1987) (Rehabilitation Act). This Court has ruled that the plaintiff has the burden of proving he does not pose a direct threat. *LaChance v. Duffy's Drafthouse, Inc.*, 146 F.3d 832, 836 (11th Cir. 1998).

Direct threat determinations must be based on an individualized assessment of the person's present ability to safely perform the essential functions of the job, considering a reasonable medical judgment relying on the most current medical knowledge and/or best available objective evidence. 29 C.F.R. § 1630.2(r). In a case involving contagious disease, this inquiry must include (a) the nature of the risk, (b) the duration of the risk, (c) the severity of the risk, and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm. *Arline*, 480 U.S.

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Supreme Court, U.S.
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(3)

No. 01-1423

IN THE
Supreme Court of the United States

SPENCER WADDELL,

Petitioner,

v.

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

~~**MOTION FOR LEAVE TO FILE BRIEF AND**~~ **BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER**

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IN THE

Supreme Court of the United States

No. 01-1423

SPENCER WADDELL,

Petitioner,

v.

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

MOTION OF THE AMERICAN DENTAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE

The American Dental Association (the "Association") hereby moves this Court pursuant to Rule 37.2(b) of the Rules of the Supreme Court for leave to file a brief as *amicus curiae* in support of the Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit. The Association has received consent from petitioner, but respondent has refused to consent.

The Association, an Illinois not-for-profit corporation founded in 1859, is the leading dental association in the United States with over 140,000 member dentists representing more than 70% of this Nation's active licensed dentists. The stated object of the Association, as set forth in its Constitution, is to "encourage the improvement of the health of the public and to promote the art and science of dentistry." The Association has a vital interest in matters that affect the oral health of the public, and a long record of educating dentists and the public about the safety of the dental office, the efficacy of infection control procedures (commonly referred to as "universal precautions"), and HIV-disease as it relates to dental treatments.

The Association seeks to submit its Brief *Amicus Curiae* in order to present to the Court information about its science based policy that the treatment of patients by a dental practitioner with HIV-disease does not pose a significant risk to patients. The Association believes this information will aid the Court in its review of the Court of Appeals decision affirming summary judgment against the petitioner Spencer Waddell.

It is also vitally important for the Court to provide clear guidance to healthcare providers and patients regarding their respective rights and obligations under the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the "Act"). Casting the provision of dental hygiene as a "significant risk" that constitutes a "direct threat," as the Eleventh Circuit did in this case, is inconsistent with this Court's decision in *Bragdon v. Abbott*, 524 U.S. 624 (1998), and conflicts with the decisions of other circuits. Reaffirmation of this Court's holdings in *Bragdon* and resolution of the circuit split on "direct threat" and the burden of proof are essential to facilitate the Association's continuing efforts to educate its

members on their responsibilities under the Act. Moreover, if left uncorrected, the Eleventh Circuit's decision threatens to undermine the public's confidence in the safety of dental treatment and the Nation's healthcare system.

The Association respectfully requests that it be granted leave to file its brief as *amicus curiae* to highlight the science that underlies its policies and the importance of this case to the country's public health.

Respectfully submitted,

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICUS 1

SUMMARY OF ARGUMENT 2

REASONS FOR GRANTING THE PETITION 4

I. THIS COURT SHOULD REAFFIRM THAT, UNDER THE AMERICANS WITH DISABILITIES ACT, A "DIRECT THREAT" MUST BE BASED ON MEDICAL OR OTHER OBJECTIVE EVIDENCE OF *SIGNIFICANT* RISK, AS OPPOSED TO THEORETICAL RISK 6

II. THIS COURT SHOULD RESOLVE SPLITS IN THE CIRCUITS REGARDING TWO KEY ASPECTS OF THE "DIRECT THREAT" DEFENSE, SIGNIFICANT RISK AND BURDEN OF PROOF. 8

A. Even In The Case Of HIV, "Direct Threat" Must Be Established By Evidence Of Significant Risk, As Opposed To Theoretical Speculation..... 9

B. The Burden Of Proving "Direct Threat" Falls On The Party Asserting The Defense..... 11

CONCLUSION 12

TABLE OF AUTHORITIES

Page

Cases

Abbott v. Bragdon, 163 F.3d 87 (1st Cir. 1998)..... 3, 5

Bragdon v. Abbott, 524 U.S. 624 (1998).....*passim*

School Bd. Of Nassau Cty. v. Arline,
480 U.S. 273 (1987)..... 6, 7

Statutes and Regulations

Americans With Disabilities Act,
42 U.S.C. § 12101, *et seq.* .....*passim*

Other Authorities

American Dental Association,
Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry (1999)..... 2, 3

American Dental Association,
Policy on HIV-Infected Dentists
(1991:592; 1997:700)..... 3

American Dental Association,
Position on AIDS, HIV Infection and the Practice of Dentistry
(1998:457; 1991:591; 1997:701) 4

INTEREST OF THE AMICUS

The AMERICAN DENTAL ASSOCIATION (the "Association"), an Illinois not-for-profit corporation founded in 1859, is the leading dental association in the United States with over 140,000 member dentists, representing approximately 70% of this Nation's active licensed dentists.[1] The stated object of the Association, as set forth in its Constitution, is to "encourage the improvement of the health of the public and to promote the art and science of dentistry." The Association has a vital interest in matters that affect the oral health of the public, and a long record of educating dentists and the public about HIV/AIDS and the safety of the dental office.

As we did in the filing of a brief in support of a petition for *certiorari* in the first ever case involving HIV to come before this Court, *Bragdon v. Abbott*, 524 U.S. 624 (1998), the Association again asks this Court to clarify what remains to many dentists and other healthcare providers an ambiguous federal law, the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the "Act"). We urge this Court to address two key questions pertaining to the Act's definition of "direct threat," so we can give appropriate guidance to our members, who can in turn use this information when treating the American public.

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief.

We are concerned that absent clarification about "direct threat," lower courts will continue to send mixed messages to health care professionals and the public about their rights and responsibilities under the Act. This will contribute to unwarranted public concerns about the safety of receiving healthcare in this country, including but not limited to care received in the dental office. To protect against these outcomes, it is critical that this Court reaffirm its position that a party raising the "direct threat" defense must do so based on medical evidence of risk, as opposed to theory.

SUMMARY OF ARGUMENT

1. This Court needs to reaffirm its previously expressed views regarding the "direct threat" defense allowed under the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the "Act"). Doing so is necessary in order to provide clear guidance to healthcare practitioners and patients alike about their rights and responsibilities under the Act, and to resolve a conflict among the circuits that has the potential for sending mixed messages to the public about the safety of the dental office and the efficacy of universal precautions. This can be best done by reinforcing that "direct threat" is established only by scientific evidence of significant risk, as opposed to theoretical speculation, and that it is the burden of the party asserting the defense to prove such risk.

As set forth in the Association's policies regarding HIV-disease and infection control, "[c]urrent and generally accepted epidemiological information supports the conclusions that (i) there is no significant risk of contracting bloodborne diseases through the provision of dental treatment when appropriate infection control procedures are followed," and (ii) the "practice of universal precautions is an effective means of reducing blood contacts that can result

in bloodborne pathogen transmission, minimizing even further the already low risk of disease transmission in the dental office." American Dental Association, *Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry* 1, 2 (1999). The Association's science based policies establish that a dental practitioner with HIV-disease does not present a significant risk to patients when appropriate infection control procedures are followed.[2]

In *Bragdon v. Abbott*, 524 U.S. 624, 651-52 (1998), this Court invited the First Circuit on remand to evaluate the scientific basis for the Association's policy. The First Circuit determined that "the origins of the [Association's] Policy satisfy any doubts regarding its scientific foundation." *Abbott v. Bragdon*, 163 F.3d 87, 90 (1st. Cir. 1998), *cert. denied* 526 U.S. 1131 (1998). Indeed, not only are the Association's policies scientifically based, it is that very science that helps the Association to naturally participate with this Court in the educative aspect of the Act, by teaching its members about the scientific basis for what is required of them under the law. This Court's clarification in *Bragdon*, both with respect to "disability" and "direct threat" helped immeasurably in the Association's efforts to educate members about their rights and responsibilities under the Act.

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[2] The Association has developed numerous policies with respect to AIDS, HIV and Infection Control since the onset of HIV-disease in this country. In 1999, most of those policies were coalesced into an umbrella *Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry*. Relevant prior policies include the Association's *Policy on HIV-Infected Dentists* (1991:592; 1997:700) and *Position on AIDS, HIV Infection and the Practice of Dentistry* (1998:457; 1991:591; 1997:701), the principal portions of which were in effect at the time of appellant's employment by appellee.

2. The conflict among the circuits identified in the instant Petition for *Certiorari* have called into question the fundamental lessons that dentists and other healthcare providers should have learned under *Bragdon*. It is important that those messages be restated by the Court and the circuit conflict be resolved in a way that clarifies that "direct threat" can be established only by scientific evidence and that the burden rests with the party asserting the defense.

Any other result risks sending mixed messages to patients and providers, both infected and uninfected alike, regarding their rights and responsibilities under the Act. Moreover, it would risk undermining the core public health message about the safety of providing dental and other healthcare in this country. This last point cannot be underestimated, given the potential for a public health crisis that could arise if healthcare providers returned to discriminating against people with HIV disease and/or the public avoids treatment upon reading headlines suggesting that federal courts have determined that the threat of HIV transmission in healthcare settings is *significant* as a matter of law.

REASONS FOR GRANTING THE PETITION

In *Bragdon v. Abbott*, 524 U.S. 624 (1998), the Court provided clear and specific guidance regarding the questions of "disability" and "direct threat." Although the Court did not determine whether there existed a "direct threat" in that case, the Court provided a veritable road map for any practitioner considering the "direct threat" defense in the context of HIV litigation. On remand in *Bragdon*, the First Circuit ruled -- consistent with Association policies about HIV, infection control and universal precautions -- that the provision of dental care in that case did not pose a direct

threat. *Abbott v. Bragdon,* 163 F.3d 87, 90 (1st Cir. 1998), *cert. denied* 526 U.S. 1131 (1999).

Based on the Court's opinion in *Bragdon*, all health practitioners should have been clear about the importance of significant risk and risk assessment in making a "direct threat" determination:

> [B]ecause few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant. *Arline, supra,* at 287, and n. 16; 42 U.S.C. § 12182 (b)(3).
>
> The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence.

524 U.S. at 649.

Furthermore, healthcare practitioners were on notice that the burden falls on the party relying on the "direct threat" defense to present objective evidence creating a triable issue of fact in order to survive a motion for summary judgment on the question of risk. *Id.* at 649-50; 664 (Rehnquist, C. J., dissenting). The Court specifically instructed the First Circuit on remand regarding the quality of evidence that a doctor asserting a "direct threat" defense would need; e.g. significant risk assessment "based on medical or other objective evidence;" the duty to assess risk "based on the objective, scientific information available to him and others in his profession;" according "special weight and authority" to "the views of public health authorities." *Id.* at 649-50.

I. THIS COURT SHOULD REAFFIRM THAT, UNDER THE AMERICANS WITH DISABILITIES ACT, A "DIRECT THREAT" MUST BE BASED ON MEDICAL OR OTHER OBJECTIVE EVIDENCE OF *SIGNIFICANT* RISK, AS OPPOSED TO THEORETICAL RISK.

Notwithstanding the clarity of this Court's opinion in *Bragdon*, the Eleventh Circuit below, and other circuits applying the "direct threat" defense, have raised serious questions about what evidence is sufficient to establish this defense. The thrust of these decisions is that, because HIV inevitably leads to death, the risk is one can that can be deemed to be "significant" even if there is no evidence to support any actual risk and the party asserting the defense acknowledges that the risk of transmission is theoretical. Essentially, this amounts to the abandonment of one of the four key inquiries of the "direct threat" analysis established by this Court in *School Bd. Of Nassau Cty. v. Arline*, 480 U.S. 273, 288 (1987), and reinforced implicitly (based upon the codification of the *Arline* approach under the Act) in *Bragdon*, 524 U.S. at 649.

The one distinct feature of the post-*Bragdon* decisions is that they have typically involved the risk of infection of the patient by a healthcare provider. This distinction makes no legal difference. Under the Act, the same "direct threat" definition applies. Indeed, if anything, science cited by every court that has squarely addressed the issue makes clear that the infinitesimal risk of transmission from infected patient to provider is greater than from infected provider to patient – the circumstances presented in this case.

The line of cases suggesting that health care workers with HIV, like Spencer Waddell, can pose a "direct threat" – usually based on theoretical risk and/or fears associated with the nature of the job -- is at odds with this Court's decision in *Bragdon* and *Arline*. These post-*Bragdon* decisions set the stage for inconsistent interpretations of the "direct threat" defense by providers and patients alike. In so doing, they also run the risk of sending at best confusing messages from the federal courts to the public about the safety of receiving healthcare.

As noted in the Petition for *Certiorari* in the instant case, "[t]he *Bragdon* standard, if applied to the undisputed facts of this case, undoubtedly would have produced a different result," than reached by the Eleventh Circuit. (Petition at 17.) In *Arline*, *Bragdon* and countless other cases, this Court and others have insisted on assessment of risk knowing full well that the risk was greater than zero. There indeed would have been no need to remand *Bragdon* had zero risk been the true measure of a "direct threat."

In addition to saddling plaintiffs "with the virtually impossible burden of proving that something that never has happened won't occur in the future" (Petition at 18), the erosion of this Court's line of authority from *Arline* to *Bragdon* has potentially far-reaching effects on the provision of healthcare in this country. Under *Arline* and *Bragdon*, it is clear to every healthcare worker that refusal to treat someone with HIV disease solely by virtue of their HIV status is unlawful. Moreover, every such practitioner should know that he or she has the burden of establishing "direct threat" by appropriate evidence rather than speculation.

By allowing theory rather than fact to prevail, the Eleventh Circuit's decision raises serious public policy concerns. Healthcare providers may now have a basis to argue, as others before have done, that there are reasonable grounds to refuse treatment of patients with HIV and other infectious diseases when the risk of doing so is death -- even if they have insufficient medical evidence to support the risk of transmission. Court decisions might suggest that the risk of transmission of HIV in healthcare settings is significant enough to allow HIV discrimination. That message by itself, in the face billions of medical and dental procedures having been safely performed since the inception of the HIV pandemic with virtually no known cases of transmission, has the potential to be injurious to healthcare providers and the patients they serve.

The clear and correct message is the one already sent by this Court: that unless and until there is adequate scientific evidence to support the existence of a significant risk, a "direct threat" defense must fail, even if the threat is with respect to a fatal disease such as HIV. Only by standing behind its line of authority that leads to this result, can this Court maintain the accuracy of the message to the American public about the safety of receiving healthcare.

II. THIS COURT SHOULD RESOLVE SPLITS IN THE CIRCUITS REGARDING TWO KEY ASPECTS OF THE "DIRECT THREAT" DEFENSE, SIGNIFICANT RISK AND BURDEN OF PROOF.

The Americans with Disabilities Act was intended by Congress, *inter alia*, to set minimum federal rights for people with disabilities and responsibilities for those providing services to them. While certainly more stringent state laws

remain in effect, the Act plainly contemplated the federal floor that could be relied upon nationwide.

As set forth in the Petition, the circuits are split on at least two significant issues regarding the "direct threat" defense in the context of HIV, significant risk and burden of proof. First, some circuits are allowing the "direct threat" defense to be pursued based on speculation and/or theoretical arguments at best. Second, some circuits are holding that the burden of proof in "direct threat" cases rest with plaintiffs alleging discrimination, who not only have to prove that they were discriminated against but also that there was no "direct threat." The Eleventh Circuit decision below suffers from both of these errors. As a result, healthcare providers and patients in that circuit arguably have different rights and responsibilities than those in other circuits that adhere more closely to the standard articulated by this Court.

A. Even In The Case Of HIV, "Direct Threat" Must Be Established By Evidence Of Significant Risk, As Opposed To Theoretical Speculation.

For there to be a uniform federal floor regarding the "direct threat" defense, this Court should resolve the conflict among the circuits by reinforcing that "direct threat" requires factual scientific support. A dental hygienist, dentist, physician or any other healthcare worker with HIV disease should have no greater or lesser rights under the Act solely by virtue of where he or she practices. In contrast neither should the federal civil rights of HIV patients receiving healthcare in this country fluctuate depending on where they seek care. In each case, both practitioner and patient are entitled to a clear understanding of what type of proof must be established to support a defense of "direct threat."

The conflict among the circuits on the "direct threat" issue greatly impedes the Association's efforts to educate our members on the law and facilitate their compliance. Before this Court's decision in *Bragdon*, some dentists raised questions whether HIV was a disease and not a disability, and whether they could refuse treatment if they believed there to be a "direct threat" of transmission to them. After *Bragdon,* it was clear that for purposes of the Act, HIV infection is usually both a disease and disability, and that healthcare providers have a significant responsibility with respect to building a "direct threat" defense based on sound science.

With the current circuit split about "direct threat," the waters are muddy once again. Now that some of the circuits have chipped away at what seemed to be a clear rule, questions are arising routinely regarding application of the Act to day-to-day dental practice. Many dentists are openly questioning whether the *Waddell* decision below has set a new standard for "direct threat." Moreover, in trying to educate dentists about how to stay within the bounds of the law, the Association is in an unenviable position. The conflict among the circuits makes it appear that the requirements of the Act depend upon where a dentist practices. The Association believes that the same scenario is playing out in other healthcare professions including medicine.

The issue does not stop with the healthcare provider side of the equation. Do individuals with HIV disease have a right to expect equal access to treatment absent a scientifically supported "direct threat" defense? Are the rights of patients with HIV disease determined by where he or she seeks treatment? Can the public rest assured that it is safe to receive healthcare in this country, or will negative

headlines questioning the safety of dental and other healthcare offices raise undue concern about HIV transmission -- perhaps particularly in parts of the country that invoke broad, speculative, *Waddell*-like versions of "direct threat?"

B. The Burden Of Proving "Direct Threat" Falls On The Party Asserting The Defense.

The conflict among the circuits regarding the burden of proof raises similar issues. Clearly, after this Court's decision in *Bragdon*, dentists and other healthcare providers reasonably believed that they had a duty to establish "direct threat" should they elect to raise the defense. However, decisions like *Waddell* below cast doubt on the burden issue. Not only might a dentist no longer have a burden to establish "direct threat;" under *Waddell*, a lay person going to her dentist for routine care, would have to produce scientific evidence regarding the safety of the care. The logic of placing plaintiffs in such a situation is difficult enough to understand. After all, they are neither claiming "direct threat" nor likely positioned, based on their experience, to make an assessment regarding the existence of "direct threat." Stranger still is any notion that a plaintiff in an HIV discrimination case would bear the burden of proving a negative, i.e., the absence of "direct threat." How this can be done, especially if "direct threat" can be established based on theory and speculation, remains a mystery.

The effect of the circuit split regarding the burden of proof could, on its own, make it difficult if not impossible for patients with HIV to effectively seek and secure healthcare in this country, depending on where they seek care. It is important that this Court address the conflict

among the circuits by reinforcing that the party relying on the "direct threat" defense has the burden of proof.

CONCLUSION

There have been two cases involving HIV discrimination in dentistry for which petitions for *certiorari* have been brought so that this Court could address critical issues under the Americans with Disabilities Act. As in *Bragdon*, the American Dental Association again urges this Court to grant the petition in order to provide clear guidance to healthcare practitioners and patients alike about their rights and responsibilities under the Act, and to resolve circuit conflicts that have the potential for sending mixed messages to the public about the safety of the dental office and the efficacy of universal precautions.

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VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF INFECTIOUS DISEASES SOCIETY OF AMERICA, HIV MEDICINE ASSOCIATION OF INFECTIOUS DISEASES SOCIETY OF AMERICA AND COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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14 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF *AMICI CURIAE* AND SUMMARY OF ARGUMENT 1

REASONS FOR GRANTING THE WRIT OF CERTIORARI 3

CONCLUSION 9

TABLE OF AUTHORITIES

Page

CASES

Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997), *aff'd in part and rev'd and remanded in part*, 524 U.S. 624 (1998) 2

Bragdon v. Abbott, 524 U.S. 624 (1998) 2, 4, 5, 7

Montalvo v. Radcliffe, 167 F.3d 873 (4th Cir. 1999), *cert. denied*, 528 U.S. 813 (1999) 2

Onishea v. Hopper, 171 F.3d 1289 (11th Cir. 1999), *cert. denied sub nom. Davis v. Hopper*, 528 U.S. 1114 (2000) 2, 5

School Bd. of Nassau County v. Arline, 480 U.S. 273 (1987) 4, 9

Waddell v. Valley Forge Dental Associates, Inc., 276 F.3d 1275 (11th Cir. 2001), *petition for cert. filed* March 20, 2002 (No. 01-1423) 1-2

STATUTES AND REGULATIONS

Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*

42 U.S.C. § 12113(b) 5

42 U.S.C. § 12182(b)(3)..... 5

OTHER AUTHORITIES

American Hospital Association, *Hospital Resources for Disaster Readiness* (November 1, 2001) *at* http://www.aha.org/Emergency/Readiness/ReadyAssessmentB1101.asp..... 8

TABLE OF AUTHORITIES – Continued

Page

Stephen Breyer, BREAKING THE VICIOUS CIRCLE: TOWARD EFFECTIVE RISK REGULATION (1993) 6

Centers for Disease Control and Prevention, *Preventing Emerging Infectious Diseases: A Strategy For the 21st Century* (October 1998) *available at* http://www.cdc.gov/ncidod/emergplan/plan98.pdf 8

Steven Eisenstat, *The HIV Infected Health Care Worker: The New AIDS Scapegoat,* 44 Rutgers L. Rev. 301 (1992) 6

John D. Graham and Jonathan Baert Wiener, *Confronting Risk Tradeoffs,* in RISK VERSUS RISK: TRADEOFFS IN PROTECTING HEALTH AND THE ENVIRONMENT 1 (John D. Graham and Jonathan Baert Wiener eds., 1995) 9

H. Clifford Lane, John La Montagne, and Anthony Fauci, *Bioterrorism: A Clear and Present Danger,* 7 Nature Medicine 1271 (2001) 7

"NIAID Releases Counter-Bioterrorism Research Agenda" Medical Letter on the CDC & FDA, Apr. 14, 2002 7

Cass R. Sunstein, *The Laws of Fear,* 115 Harv. L. Rev. 1119 (2002) (reviewing Paul Slovic, THE PERCEPTION OF RISK (2000)) 6

W. Kip Viscusi, RATIONAL RISK POLICY (1998) 7

INTEREST OF *AMICI CURIAE* AND SUMMARY OF ARGUMENT[1]

This *amici curiae* brief in support of the petition for certiorari is submitted on behalf of the Infectious Diseases Society of America, the HIV Medicine Association of the Infectious Diseases Society of America, and the Council of State and Territorial Epidemiologists (the "*Amici*"). The brief is filed with the consent of the parties.[2]

Our nation faces pressing public health and disease prevention challenges, such as new and emerging infectious diseases, and the threat of bioterrorism. An effective response to these and other actual dangers to the public health requires a rational, scientific, and consistent approach to risk assessment in order to direct finite resources towards threats that are both real and preventable.

The decision of the Eleventh Circuit in this case, like several other recent decisions of the courts of appeals, holds that a theoretical risk of harm satisfies the "direct threat" defense provision of the Americans with Disabilities Act (ADA).[3] This "zero-risk" approach, even where

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *Amici* state that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *Amici* and their counsel made any monetary contribution to the preparation or submission of this brief.

[2] Letters of consent from the parties have been filed separately with the Clerk of Court.

[3] *Waddell v. Valley Forge Dental Associates, Inc.*, 276 F.3d 1275, 1282 (11th Cir. 2001), *petition for cert. filed* March 20, 2002

the postulated risk is eventual death, is inconsistent with the measured, scientific foundation upon which medical judgments about risks must be based. A zero-risk standard, if not corrected by this Court, will interfere with critical public health efforts by encouraging health care institutions to expend scarce resources on illusory risks at a time when the country can ill afford to do so. A zero-risk standard does not promote health or safety; to the contrary, it is more likely to increase the risk of the very harms it seeks to prevent.

The *Amici* have expertise in the prevention and control of infectious diseases that threaten the public health. The Infectious Diseases Society of America represents almost 6,000 physicians, scientists, and other health professionals dedicated to excellence in patient care, research, and public health disease prevention and education in the field of infectious diseases. Infectious diseases is a board certified subspecialty of internal medicine and

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(No. 01-1423). *See also Onishea v. Hopper*, 171 F.3d 1289, 1299 (11th Cir. 1999), *cert. denied sub nom. Davis v. Hopper*, 528 U.S. 1114 (2000) ("direct threat" exists whenever there is "evidence that the asserted risk of transmission has a sound theoretical basis," regardless of scientific evidence regarding probability); *Montalvo v. Radcliffe*, 167 F.3d 873, 877-78 (4th Cir. 1999), *cert. denied*, 528 U.S. 813 (1999) (upholding dismissal of HIV-positive student from karate school even though transmission had never occurred in that or a similar setting). In contrast, *see Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) (assessment of "direct threat" requires consideration of the level of risk and the statistical likelihood of occurrence); *Abbott v. Bragdon*, 107 F.3d 934, 948 (1st Cir. 1997), *aff'd in relevant part*, 524 U.S. 624 (1998) (in asserting direct threat defense, "a service provider like Dr. Bragdon is not entitled to demand absolute safety.").

pediatrics. The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America provides a forum for physicians, scientists, and other health care professionals dedicated to the field of HIV/AIDS. HIVMA reflects the variety of medical disciplines engaged in HIV care and research and serves to advance the interests of patients with HIV and to unite providers who work on the front line of the HIV/AIDS epidemic.

The Council of State and Territorial Epidemiologists is a professional association of 400 epidemiologists in all of the states and territories of the United States working together to detect, prevent, and control conditions of public health significance. Its membership includes the official state epidemiologist of every state and territory. Members of the Council are public health scientists on the front lines of the battle against infectious diseases and bioterrorism.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

The lower court's decision is striking because *all* of the expert testimony in the record concluded that the risk that the plaintiff, a dental hygienist with HIV, would transmit the virus to a patient was so low as to be virtually non-existent. The Eleventh Circuit nonetheless held that Mr. Waddell posed a significant risk because there was a *theoretical* risk of transmission that could not be entirely ruled out. This new legal standard, now clearly established in the Eleventh and Fourth Circuit

Courts of Appeals,[4] represents a significant threat to public health. It should be promptly addressed and corrected by this Court.

In *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), and *Bragdon v. Abbott*, 524 U.S. 624 (1998), this Court held that the disability discrimination laws are predicated on a rational approach to assessing health and safety risks based on sound public health principles. A scientific approach to risk assessment is particularly important in disability discrimination law because contagious diseases, like other disabilities, historically have been subject to myths, fears, and stereotypes. *Arline*, 480 U.S. at 284 & n.12 (noting the "complex and often pernicious mythologies about . . . the transmission of illness;" "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness."). At the same time, this Court has been mindful that contagious diseases could pose a health risk to others. In balancing the need to reject exaggerated fears of danger with the goal of avoiding exposing others to real health risks, the Court specified four factors to be weighed[5] and declared that assessments of risk must be

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[4] *See* n.3, *supra*.

[5] Whether an individual with a disability poses a "significant risk" to others requires: "findings of fact, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (*e.g.*, how the disease is transmitted), (b) the duration of the risk (how long the carrier is infectious), (c) the severity of the risk (what is the potential harm to third parties), and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm." *Arline*, 480 U.S. at 274. The ADA's "direct threat" defense codifies this

based on objective medical evidence with deference given to the views of public health authorities. *Bragdon*, 524 U.S. at 650. Indeed, the "direct threat" test first formulated in *Arline* reflects the medical community's scientific approach to assessing the risk of disease transmission. *Arline*, 480 U.S. at 288 (adopting the "direct threat" test from *amicus* American Medical Association).

This sound approach to risk assessment is threatened by the decision below and other recent appellate court rulings interpreting the ADA's "direct threat" provision to require a zero-risk standard. The public health authorities who testified in the instant case unanimously concluded that the plaintiff did not pose a significant risk to his patients and that there was no basis to categorically exclude health care workers with HIV such as Mr. Waddell from practicing their professions. The Eleventh Circuit disregarded their conclusion, not because of a "credible scientific basis for deviating from the accepted norm," *Bragdon*, 524 U.S. at 650, but because of its unlawful zero-risk legal standard. This holding not only aggravates a conflict among the courts of appeals,[6] but also flies in the face of fundamental tenets of public health.

Leading authorities on rational risk assessment have condemned the notion of zero-risk as a completely

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standard. *Bragdon*, 524 U.S. at 649; 42 U.S.C. §§ 12113(b) & 12182(b)(3).

[6] *See Onishea*, 171 F.3d at 1297 (noting conflict among the courts of appeals about "how low the odds may be, and how much evidence it takes to prove a significant risk.").

unworkable basis for establishing law and public policy.[7] As observed by Professor Cass Sunstein, the logic of the zero-risk approach is to respond to even a virtually impossible scenario of grave harm with the question: "Well, it could happen, couldn't it?"[8] Public policy should not, and, indeed, cannot consistently be based on the principle that even a 99.99% assurance of safety is insufficient.[9] Professor Sunstein and others attribute this fallacy to a predictable, but unsound, emotional inclination to misperceive and overreact to particular types of risk.[10] Because a zero-risk standard is impossible to apply consistently, incorporating such a standard into the ADA's "direct threat" test opens the door to precisely the type of

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[7] *E.g.*, Cass R. Sunstein, *The Laws of Fear*, 115 Harv. L. Rev. 1119, 1119-1120, 1123, 1129, 1137 (2002) (reviewing Paul Slovic, THE PERCEPTION OF RISK (2000)).

[8] *Id.* at 1119-1120.

[9] Steven Eisenstat, *The HIV Infected Health Care Worker: The New AIDS Scapegoat*, 44 Rutgers L. Rev. 301, 320 (1992).

[10] Sunstein, *supra* n.7, at 1123, 1129, 1137 ("ordinary people often deal poorly with the topic of risk . . . [based on] "predictable features of human cognition;" "people tend to subscribe to the 'zero-risk' mentality, at least in some domains, apparently believing that it is both possible and appropriate to eliminate risk entirely;" "when strong emotions are at work, people tend to focus on the 'worst case,' in a way that makes the outcome, but not its probability, highly salient"). *See also* Stephen Breyer, BREAKING THE VICIOUS CIRCLE: TOWARD EFFECTIVE RISK REGULATION 35-36 (1993) (setting out the various psychological factors that impede "rational reactions to risk" and observing that "[m]ost people have considerable difficulty understanding the mathematical probabilities involved in assessing risk . . . [and] consistently overestimate small probabilities . . . [and] underestimate large ones.").

discrimination against persons with disabilities, based on irrational fears, that the ADA was intended to prevent. An essential bulwark against this kind of inconsistent, discriminatory approach to assessing risks is the requirement that an assessment of direct threat be based on the statistical likelihood that a feared event will occur. *See Bragdon*, 524 U.S. at 652.

The recent tendency of courts to adopt a zero-risk approach with respect to illusory risks is especially dangerous in the health care context. It is beyond cavil that our society does not have sufficient resources to eliminate entirely even risks that have been demonstrated to result in death.[11] Rules of law that support a lopsided direction of resources toward the elimination of theoretical risks are harmful in at least two ways.

First, such legal decisions undermine efforts of the public health system to marshal resources to address real risks, many of which may emerge suddenly and call for a prompt response. For example, as the Director of the National Institute of Allergies and Infectious Diseases, Dr. Anthony Fauci, wrote recently, the threat of bioterrorism has been transformed from "what was once a theoretical concern . . . [to] a clear and present danger."[12] President Bush has proposed a $1.2 billion increase in bioterrorism funding.[13] The American Hospital

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[11] W. Kip Viscusi, RATIONAL RISK POLICY 97 (1998).

[12] H. Clifford Lane, John La Montagne, and Anthony Fauci, *Bioterrorism: A Clear and Present Danger*, 7 Nature Medicine 1271, 1273 (2001).

[13] *"NIAID Releases Counter-Bioterrorism Research Agenda"* Medical Letter on the CDC & FDA, Apr. 14, 2002, at 2.

Association has distributed new guidelines to 4,900 acute care facilities to "increase hospital readiness" to respond to nuclear, biological, and chemical attacks, including increased disease surveillance capacity, dedicated decontamination facilities, and "staff training at all levels of the organization."[14] In another area, the United States Centers for Disease Control and Prevention (CDC) has warned that new infectious diseases and diseases that are becoming resistant to current treatment, such as multidrug resistant tuberculosis, are a "major threat to U.S. health" and "are swiftly reversing miracles of the previous 50 years."[15] The CDC observed that significantly increased resources are needed to develop new expertise in the diagnosis and treatment of certain diseases rarely seen in this country.[16] Public health authorities and medical institutions in this country will be severely compromised in efforts to meet these and other new threats if legal decisions encourage resources to be directed towards risks that are merely theoretical.

Second, sanctioning discrimination based on a theoretical risk does not increase safety, but in fact may increase risks to others.[17] This case provides one example.

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[14] American Hospital Association, *Hospital Resources for Disaster Readiness* (November 1, 2001) *at* http://www.aha.org/Emergency/Readiness/ReadyAssessmentB1101.asp.

[15] Centers for Disease Control and Prevention, *Preventing Emerging Infectious Diseases: A Strategy For the 21st Century*, 3, 8 (October 1998) *available at* www.cdc.gov/ncidod/emergplan/plan98.pdf.

[16] *Id.* at 39.

[17] It is well established in the field of risk prevention that "[p]aradoxically some of the most well-intentioned efforts to

The development of competent and highly trained health care workers is one of the key components to creating safe conditions for patients. Removing a health care worker whose qualifications are not in dispute based on an illusory risk can result in the replacement of a skilled professional with a less experienced worker, with an actual reduction in the level of care and safety provided to the patient. Moreover, public health is best secured by the early detection, diagnosis and treatment of infectious diseases. This principle ensures that individuals with contagious diseases receive prompt treatment and slows the spread of epidemics by facilitating counseling about how to avoid transmitting the disease to others. As the Court recognized in *Arline*, 480 U.S. at 286 n.15, a rule that permits discrimination based on illusory risks encourages people to hide rather than seeking testing and medical care.

CONCLUSION

As the Court recognized in *Arline*, 480 U.S. at 286 n.15, a rule this Court has played a critical role in ensuring that assessments of health risks in our legal system are based on sound scientific principles. The *Amici* respectfully request that the Court grant the petition for a writ of certiorari in order to clarify that the "direct

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reduce identified risks can turn out to increase other risks." John D. Graham and Jonathan Baert Wiener, *Confronting Risk Tradeoffs*, in RISK VERSUS RISK: TRADEOFFS IN PROTECTING HEALTH AND THE ENVIRONMENT 1 (John D. Graham and Jonathan Baert Wiener eds., 1995).

threat" defense under the ADA should not be analyzed under a zero-risk standard.

Respectfully submitted,

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